Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39501

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ada Susan Williamson
2. Data of Death Month Day Yaar: December 13, 1999
3. Tima of Death: 3:30pm
4a. Facility Name (If not institution, giva street and number): 1411 Foxwood Court
4b. City, Town, or Location of Deeth: Annapolis
4c. County of Deeth: Anne Arundel

Funeral Director

5. Social Security Number: 368-40-7443
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec.29,1910
9. Birthplace (State or Foreign Country): Michigan

Usual Rasidance of Dacedent

10a. Stata: MD
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 1411 Foxwood Court
10f. Zip Coda: 21401
10g. Citizan of What Country?: USA

11. Meritel Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yes, Give Yeer or Datas:
13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Ricen, atc.) 1☐ Yes 2☒ No Specify:
14. Race - Amarican Indian, Black, Whita, atc. Specify: White

15. Decedant's Educetion (Specify only highast grada complated)
Elementary/Secondary (0-12):
College (1-4or 5+): UNK
16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT usa retired): Teacher
16b. Kind of Businass/Industry: Education

17. Father's Neme (First, Middla, Last): Clarence Carpenter
18. Mothar's Nama (First, Middla, Maiden Surneme): Myrtle Rumbaugh

19a. Informant's Name/Reletionship (Type, Print): Lila Williamson - Daughter
19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Coda): 1411 Foxwood Court, Annapolis, MD 21401

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramovel from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or other place): Frye Cemetery
Data: 12/17/99
20c. Location - City or Town, Stata: Bronson, Michigan

21. Signeture of Funaral Service Licensee: Michael G. Hutta
22. Nama and Addrass of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications thet caused the daath. Do not antar the moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Immediata Causa (Final diseasa or condition rasulting in death): a. Breast cancer — Approximate Intarval Batween Onsat and Death: 24 years

Dua to (or as a consequance of):

Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Ceuse (Disaasa or Injury that initieted evants rasulting in daath) Last:
b. Dua to (or es e consequence of):
c. Dua to (or as a consaquence of):
d.

Part II. **Other eignificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cauee of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Wara autopsy findings avellabla prior to complation of cause of death? 1☐ Yas 2☐ No

25. Was cesa rafarred to medicel examinar? 1☐ Yas 2☒ No

28. Place of Daath (Check only ona)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Othar: 4☐ Nursing Home 5☒ Rasidance 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined
28a. Data of Injury (Month, Day Year)
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rurel Routa Numbar, City or Town, Stata)

29a. Cartifiar (Check only one): 1☑ **Certifying Physician:** To tha bast of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar stated.

29b. Signeture and title of cartifiar: J. Selonick, M.D.
29c. Licansa number: D19838
29d. Data signed (Month, Day, Yaar): 12/14/99

30. Nama and addrass of person who complated causa of daath (Item 23a) (Type, Print): Stuart E. Selonick, M.D. 900 Bestgate Rd. Annapolis, md.

State Registrar

31. Data filed (Month, Day, Year): DEC 17 1999
32. Registrar's Signatura: B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39502

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Leonard Wingle
2. Date of Death (Month, Day, Year): December 14, 1999
3. Time of Death: 10:05 A.M.
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 205 05 0801
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 19. 1913
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 36 Wagners Lane
10f. Zip Code: 21221
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Steelworker
16b. Kind of Business/Industry: Beth. Steel Corp.
17. Father's Name (First, Middle, Last): James Wingle
18. Mother's Name (First, Middle, Meiden Surname): Lily E. Kramer
19a. Informant's Name/Relationship (Type, Print): Charle Wingle Jr. (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 26 Avenal Road Essex, Maryland 21221
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Belair Memorial Gradens
Date: 12/17/99
20c. Location - City or Town, State: Belair, Maryland
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Bruzdzinski Funeral Home PA 1407 Old eastern aVenue Essex, Maryland 21221

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Wingle Charles
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finet disease or condition resulting in death)
a. Hypotension — 5 Minutes
Due to (or as a consequence of):
b. Aortic Aneurysm
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic Renal Failure, Coronary Artery Disease, Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Rachel Benn MD
29c. License number: RD 198994
29d. Date signed (Month, Day, Year): December 14, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Rachel Benn 9000 Franklin Square Drive Baltimore, MD 21237

State Registrar

31. Date filed (Month, Day, Year): DEC 17 1999
32. Registrar's Signature: [signature] D. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39503

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES WILLIAMS
2. Date of Death (Month, Day, Year): DECEMBER 14 1999
3. Time of Death: 01:15AM
4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 220-24-8096
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 68 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 25, 1931
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 140 North Lakewood Avenue
10f. Zip Code: 21224
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Inspector
16b. Kind of Business/Industry: Mfg.
17. Father's Name (First, Middle, Last): Frank B. Williams
18. Mother's Name (First, Middle, Maiden Surname): Willetta Unknown
19a. Informant's Name/Relationship (Type, Print): Mary E. White / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 916 Catawba Court, Baltimore, Maryland 21227
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery
Date: 12/17/99
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. METASTATIC LUNG CANCER — 4 WEEKS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MICHAEL BAALO, RESIDENT
29c. License number: P12705
29d. Date signed (Month, Day, Year): DECEMBER 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL BAALO, JHH, 600 N. WOLFE ST, BALTIMORE, MD 21287

State Registrar

31. Date filed (Month, Day, Year): DEC 17 1999
32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39504

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Irene E. Weaver

2. Date of Death Month / Day / Year: December 12 1999

3. Time of Death: 2110 AM

4a. Facility Name *(If not institution, give street and number)*: St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore MD

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 184-20-0001

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 20, 1927

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1937 Sponson Street

10f. Zip Code: 21230

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Executive

16b. Kind of Business/Industry: Direct Marketing

17. Father's Name *(First, Middle, Last)*: Russell Snyder

18. Mother's Name *(First, Middle, Maiden Surname)*: Edith Scovern

19a. Informant's Name/Relationship *(Type, Print)*: Curtis W. Weaver, Sr./ Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1937 Sponson Street Baltimore, Maryland 21230

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Meadowridge Mem. Park

Date: 12/16/99

20c. Location - City or Town, State: Elkridge, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List *only one* ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death)

a. Cerebral Vascular Accident — 2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ____

Due to (or as a consequenca of):

c. ____

Due to (or as a consequenca of):

d. ____

Part II. **Other eignificant conditione** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco uee contribute to the cause of death? 1☐ Yee 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: MD

29c. License number: P 13594

29d. Date signed *(Month, Day, Year)*: December 12 1999

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): St. Agnes Hospital 900 Caton Ave Baltimore MD 21229

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 17 1999

32. Registrar's Signatura

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

NAME Weaver, Irene

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39505

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alan W. Wescoat
2. Date of Death: Month December, Day 13, Year 1999
3. Time of Death: 3:42 p.m.
4a. Facility Name (If not institution, give street and number): 2617 Pelham Avenue
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-46-7459
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 51 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 1, 1948
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2617 Pelham Avenue
10f. Zip Code: 21213
10g. Citizen of What Country? United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Press Operator
16b. Kind of Business/Industry: Steel Production

17. Father's Name (First, Middle, Last): Winfield Wescoat
18. Mother's Name (First, Middle, Maiden Surname): Evelyn Williams

19a. Informant's Name/Relationship (Type, Print): Linda R. Wescoat (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2617 Pelham Avenue Baltimore, Md. 21213

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp.
Date: 12/16/99
20c. Location - City or Town, State: Towson Maryland

21. Signature of Funeral Service Licensee: Milton J. Knight Jr
22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Ventricular Arrhythmia
Due to (or as a consequence of):
b. Cardiomyopathy
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D15476
29d. Date signed (Month, Day, Year): 12/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ronald Sherr 575 Fairmount Ave. Towson MD 21286

State Registrar

31. Date filed (Month, Day, Year): DEC 17 1999
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39506

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Blanche T. Allen
2. Date of Death Month / Day / Year: November 30 1999
3. Time of Death: 3:50PM
4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-44-5658
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 18, 1934
9. Birthplace *(State or Foreign Country)*: Wash., D.C.

Usual Residence of Decedent

10a. State: District of Columbia
10b. County:
10c. City, Town or Location: Washington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 766 Kennedy St., N.E.
10f. Zip Code: 20011
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* African American
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Lecturer/Minister/Teacher
16b. Kind of Business/Industry: Private
17. Father's Name *(First, Middle, Last)*: Maynard Wilson Turner
18. Mother's Name *(First, Middle, Maiden Surname)*: Ella Goldsby
19a. Informant's Name/Relationship *(Type, Print)*: Eugene J. Allen - Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 766 Kennedy St., N.E. Wash., D.C. 20011
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Ft. Lincoln Cemetery
Date: 12/6/99
20c. Location - City or Town, State: Brentwood, MD
21. Signature of Funeral Service Licensee: John T. Stewart, III
22. Name and Address of Facility: Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Acute Renal Failure	5 Weeks
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Widely Metastatic Endometrial Cancer	3 Years
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Rectovaginal, Vesicovaginal Fistula

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Brian F. Reagan MD
29c. License number: DO 045121
29d. Date signed *(Month, Day, Year)*: November 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Brian F. Reagan, M.D.; 1500 Forest Glen Road, Silver Spring, MD

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 02 1999
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DEC 0 3 1888

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39507

Amend #1 Per Phys. PGC 12-3-99 cr

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last): Joaquin Cruz ~~Arrag~~ Aruag

2. Data of Death Month: Nov Day: 29 Year: 1999

3. Time of Death: 1517

4a Facility Nama (If not institution, giva street and number): Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

5. Social Security Number: 212-27-5458

6. Sex: 1☒ M 2☐ F

7. Aga (In yrs. last birthday): 74 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 08-25-25

9. Birthplace (State or Foreign Country): El Salvador

Usual Rasidance of Decedent

10a. Steta: Md.

10b. County: Montgomery

10c. City, Town or Locafion: Silver Spring

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 10453 Malone Street

10f. Zip Code: 20902

10g. Citizen of What Country?: El Salvador

11. Marifel Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaer or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1☒ Yes 2☐ No Specify: El Salvadoran

14. Race - Amarican Indian, Black, Whita, atc. Specify: El Salvadoran

15. Decedant's Education (Specify only highast grada complatad): Elamantary/Secondary (0-12): 3rd; Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): Custodian

16b. Kind of Business/Industry: Government

17. Father's Nama (First, Middle, Last): Romona Calderon

18. Mother's Name (First, Middla, Maiden Sumama): Herminia Cruz

19a. Informant's Name/Relationship (Type, Print): Ada Cruz Daughter

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 10453 Malone St. Silver Spring, Md. 20902

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of camatary, cramatory or othar place): Family Cemetery

Date: 12-09-99

20c. Location - City or Town, Stata: San Salvador, El Salvador, C.A.

21. Signafure of Funeral Sarvice Licensee: ▶Wanda C. Bacon CC0361

22. Neme and Address of Facility: W. H. BACON FUNERAL HOME, INC. 3447 14th St., N. W. Washington, D.C. 20010

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused the daath. Do not entar the moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only ona causa on each tine.

Approximata Intarval Batween Onset and Deeth

Immediata Causa (Finat disaasa or condition rasulting in daath)

a. Probable myocardial infarction — DOME

Dua to (or as a consequence of):

Sequantially list conditions, if any, laading to immadiate causa. Entar Undarlying Cause (Disaasa or Injury that initiated avants rasulting in death) Last

b. Dua to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the causs of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa referred to medical examinar? 1☒ Yas 2☐ No

26. Place of Death (Check only ona)

Hospifel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Rasidence 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Locafion (Street and Number or Rural Routa Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Cartifiar (Check only one): 1☐ **Certifying Physician**: To tha best of my knowledge, death occurred at tha tima, date and place, and dua to tha cause(s) and manner as stated. 2☒ **Medical Examiner**: On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and ptace, and due to tha cause(s) and mannar stated.

29b. Signafura and fitla of cartifier: ▶Ira N Brecker MD ME

29c. Licansa number: D004248

29d. Date signed (Month, Day, Year): Nov 29, 1999

30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Type, Print): IRA N BRECKER, MD ME 2101 Medical Park Dr Silver Spring MD 20902

(3)

State Registrar

31. Data filed (Month, Day, Year): DEC 03 1999

32. Registrar's Signature: Donna S. Lewis

DHMH 16 Rev 6/95

ORIGINAL

DEC 0 3 1998

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39508

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Rhoda Louise Ashby
2. Date of Death Month Day Year: November 29, 1999
3. Time of Death: 6:00p.m.
4a. Facility Name *(If not institution, give street and number)*: Prince George's Hospital Center
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-20-4048
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 16, 1922
9. Birthplace *(State or Foreign Country)*: Washington,D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4200 Emerson Street
10f. Zip Coda: 20781-0023
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 3
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Paul Rea
18. Mother's Name *(First, Middle, Maiden Surname)*: Rhoda Louise Baggett

19a. Informant's Name/Relationship *(Type, Print)*: Ray Ashby - Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4200 Emerson Street, Hyattsville, MD 20781-0023

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MD Veteran's Cemetery
Date: 12/6/99
20c. Location - City or Town, State: Cheltenham, Maryland

21. Signature of Funeral Service Licensee: ▶ Claudette L. Gasch
22. Name and Address of Facility: Gasch's Funeral Home 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Intracerebral Hemorrhage — 4 days
Due to (or as a consequence of):
b. Hypertension — + yrs
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☒ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: D3018
29d. Date signed *(Month, Day, Year)*: 11/30/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Catazenis 3001 Hosptial Drive, Cheverly, Maryland 20785

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 03 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DEC 0 3 1988

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39509

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): OPAL AGAMENNONE
2. Dete of Deeth: Month NOVEMBER Dey 25, Yeer 1999
3. Time of Deeth: 01:05 AM
4e. Facility Name (If not institution, give street end number): Calvert Memorial Hospital
4b. City, Town, or Location of Deeth: Prince Frederick
4c. County of Deeth: Calvert

Funeral Director

5. Social Security Number: 238-24-0507
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): Jan 5,1921
9. Birthpiece (Stete or Foreign Country): West Virginia

Usuei Residence of Decedent

10a. State: Md.
10b. County: Anne Arundel
10c. City, Town or Location: Crofton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 1660 Yorktown Court
10f. Zip Code: 21114
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indien, Bieck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12) / College (1-4or 5+): 2
16e. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: U.S. Gov't

17. Fether's Neme (First, Middle, Last): Coy C. McNeill
18. Mother's Neme (First, Middle, Meiden Surneme): Ressie Fletcher

19e. Informent's Name/Reietionship (Type, Print): R. Keith Agamennone-son
19b. Meiling Address (Street end Number or Rurei Route Number, City or Town, Stete, Zip Code): 1660 Yorktown Court, Crofton, Md. 21114

20a. Method of Disposition: 1☒ Buriai 2☐ Cremation 3☐ Removei from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Md. Veterans Cemetery Date: 12-01-99
20c. Location - City or Town, Stete: Cheltenham, Md.

21. Signeture of Funerei Service Licensee: ▶ Robert G. Beall M00025
22. Neme end Address of Feciiity: Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Md. 20715

Physician /Medical Examiner

23a. Pert1. Enter the disease, or compiicetions thet ceused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert feiture. List oniy one ceuse on eech line. — Approximete Intervei Between Onset end Deeth

Immediete Ceuse (Finei diseese or condition resulting in deeth): e. MYOCARDIAL INFARCTION
Due to (or es e consequence of):
Sequentiaiiy list conditions, if eny, ieeding to immediete ceuse. Enter Underiying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Last:
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.: Diabeter Mellifus, Chronic Obstructive, Pulmonary disease, Ischemic Heart Disease, Congestive Heart Failure, probable Lung Cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings evaiiable prior to compietion of ceuse of deeth? 1☐ Yes 2☒ No

25. Was cese referred to medicei exeminer? 1☐ Yes 2☒ No
26. Piece of Deeth (Check only one): Hospitel: 1☐ inpetient 2☒ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturei 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rurei Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Phyeician:** To the best of my knowiedge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medicei Exeminer:** On the basis of exemination end/or investigetion, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: ▶ [signature]
29c. License number: D50763
29d. Dete signed (Month, Dey, Yeer): 11/25/99

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): FULTON LOKBAN M.D., CALVERT MEMORIAL HOSPITAL - ER DEPT.

State Registrar

31. Date filed (Month, Dey, Yeer): NOV 29 1999
32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours efter death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the buriei-transit permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is merkeid other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39510

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Adour Adrouny

2. Date of Death (Month, Day, Year): November 24, 1999

3. Time of Death: 5:30 AM

4a. Facility Name (If not institution, give street end number): 103 Amberfield Lane

4b. City, Town, or Location of Death: Gaithersburg

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 252-58-0821

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 1, 1916

9. Birthplace (State or Foreign Country): Turkey

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 103 Amberfield Lane

10f. Zip Code: 20878

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Professor

16b. Kind of Business/Industry: Medical School

17. Father's Name (First, Middle, Last): Adour Adrouny

18. Mother's Name (First, Middle, Maiden Surname): Ovsanna Meshefejian

19a. Informant's Name/Relationship (Type, Print): Sonia A. Russo/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14801 Keeneland Circle, North Potomac, MD 20878

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park

Date: Nov. 29, 1999

20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: Robert Funke M00198

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. LUNG CANCER — 2 1/2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Carl L. Schoenberger MD

29c. License number: D26540

29d. Date signed (Month, Day, Year): NOV 24 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Carl L. Schoenberger MD 16220 Frederick Rd Gaithersburg MD

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999

32. Registrar's Signature: Jeanne G. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39511

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret Mary Angell
2. Date of Death (Month, Day, Year): November 24, 1999
3. Time of Death: 10:40 PM
4a. Facility Name (If not institution, give street and number): 7602 Hamilton Spring Road
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 570-44-8092
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 28, 1927
9. Birthplace (State or Foreign Country): Ireland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Insida City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7602 Hamilton Spring
10f. Zip Code: 20817
10g. Citizen of Whet Country?: United States

11. Meritel Status: 1☐ Never Merried 2☒ Merried 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yas 2☒ No If Yes, Giva Year or Datas:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No Specify:
14. Race - Americen Indien, Bleck, White, etc. Specify: White

15. Decedent'e Education (Specify only highest grade completed): Elementery/Secondary (0-12) | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of BusInass/Industry: Own Home

17. Father's Name (First, Middle, Last): Walter Francis McCaffrey
18. Mother's Neme (First, Middle, Maiden Surneme): Lillian Daly

19a. Informent's Name/Relationship (Type, Print): James Kennedy Angell (husband)
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 7602 Hamilton Spring Road, Bethesda, Maryland 20817

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetary, crematory or other place): Chesapeake Crematory
Date: 11-26-99
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funarel Service Licensee: Carola DeLn
22. Name and Address of Facility: Rapp Funeral & Cremation Services, Stephen D. Lohrmann, P.A. 933 Gist Avenue, Silver Spring, MD 20910

Physician /Medical Examiner

23a. Pert1. Enter tha disease, or complications that caused tha death. Do not entar the mode of dying, such es cardiac or raspiratory arrast, shock, or heart failure. List only one cause on aach lina.

Approximata Intarval Batween Onset end Death

Immediate Causa (Final diseasa or condition resulting in death)
a. Cardiopulmonary Failure — Acute

Due to (or es e consequence of):
b. Lung Cancer

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initieted events resulting in death) Last
c.

Due to (or es a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco uee con1ribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Wera eutopsy findings aveilable prior to complation of ceuse of daath? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only ona): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledge, death occurred et the tima, data end plece, end due to the causa(s) and mannar es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, daath occurred et the time, date end place, end due to the cause(s) and manner steted.

29b. Signature and title of certifier: JMWMK M.D.
29c. License number: MD 53177
29d. Date signed (Month, Day, Year): November 26, 1999

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print): John M. Wallmark, M.D., 9707 Medical Center Drive, Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999
32. Registrar's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39512

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ann B. Armstrong

2. Date of Death Month Day Year: November 27, 1999

3. Time of Death: 3:30 PM

4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-30-7582

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 26, 1913

9. Birthplace (State or Foreign Country): Wisconsin

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3459 Chiswick Drive

10f. Zip Code: 20906

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Economist

16b. Kind of Business/Industry: National Institutes of Health

17. Father's Name (First, Middle, Last): Carl A. Baumann

18. Mother's Name (First, Middle, Maiden Surname): Lillian McManman

19a. Informant's Name/Relationship (Type, Print): Kenneth Armstrong/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13412 Cleveland Drive, Rockville, Maryland 20850

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Gabriel's Parish Cemetery

Date: Nov. 30, 1999

20c. Location - City or Town, State: Potomac, Maryland

21. Signature of Funeral Service Licensee: Ray Faust M00198

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Ischemia of Intestine

Due to (or as a consequence of):

c. Fat Emboli

Due to (or as a consequence of):

d. Fracture Femur

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): Nov. 17, 1999

28b. Time of Injury: 1500 P M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: Slipped on floor at home

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): At Home

28f. Location (Street and Number or Rural Route Number, City or Town, State): 3459 Chiswick Drive Silver Spring, Maryland 20906

29a. Certifier (Check only one)

1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D. (OME)

29c. License number: D15236

29d. Date signed (Month, Day, Year): November 28, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): CARL I. MARGOLIS, M.D. 11125 Rockville Pike, Rockville MD 20852

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend item 10e per fh/daughter G780
2/10/00 yg

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39513

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month Day Year	3. Tima of Death
Amelia Reinhard Auer	November 26, 1999	2:20 PM

4a Facility Nama (If not institution, giva street and number)	4b. City, Town, or Location of Death	4c. County of Death
Suburban Hospital	Bethesda	Montgomery

Funeral Director

5. Social Security Number	6. Sax	7. Aga (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplaca (State or Foreign Country)
212-64-5589	1☐ M 2☒ F	73 Yrs.			Aug. 11, 1926	Maryland

Usual Residence of Decedent

10a. Stata	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Poolesville	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
~~16815 Budd Road~~ 5550 Tuckerman Lane Rockville, MD 20852	20837	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Nevar Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yas, Giva Yaar or Detas:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highast grade completed)		16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired)	16b. Kind of Business/Industry
Elamentary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Fathar's Name (First, Middla, Last)	18. Mother's Nama (First, Middle, Maiden Surnama)
John Reinhard	Emilie Caroline Oesterle

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code)
Kathleen Auer Mihm (daughter)	16815 Budd Road, Poolesville, Maryland 20837

20a. Method of Disposition	20b. Place of Disposition (Nama of cematary, crematory or other place)	Data	20c. Location - City or Town, Stata
1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)	New Cathedral Cemetery	11-29-99	Irvington, Maryland

21. Signatura of Funaral Sarvice Licensee	22. Nama and Address of Facility
Carol A Dehn	Rapp Funeral & Cremation Services, Stephen D. Lohrmann, PA 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complications thet caused tha death. Do not entar the mode of dying, such as cardiac or respiretory arrest, shock, or haart failura. List only one ceuse on aach line.

		Approximate Interval Between Onset and Death
Immediata Ceusa (Final disaasa or condition rasulting in deeth) a.	Urosepsis	6 ds
Dua to (or as a consequence of): b.	Pyelonephritis	6 ds
Sequentially list conditions, if any, leeding to immadiata cause. Enter Underlying Cause (Disaasa or Injury that initiated avants rasulting in deeth) Last — Dua to (or as a consequence of): c.		
Dua to (or as a consequence of): d.		

Part II. **Other significant conditiona** contributing to death but not resulting in tha underlying cause given in Part I.

Rheumatoid arthritis

Adrenal insufficiency

23b. Did tobacco use contribute to the cause of death? 1☐ Yaa 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yas 2☒ No

25. Was casa rafarred to medical examinar?	26. Place of Deeth (Check only one)	
1☐ Yas 2☒ No	Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Mannar of Death	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datermined		M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, tarm, street, factory, office building, atc. (Specify)	28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one) 1☒ **Certifying Physician:** To tha best of my knowledge, death occurred at the time, data and place, and due to the cause(s) end manner as stated.
2☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, deeth occurred at the tima, date and place, and dua to the cause(s) and mannar stated.

29b. Signature and title of certifier	29c. License number	29d. Data signed (Month, Day, Year)
Sjoerd Beck MD	D 46052	11/26/99

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)
Sjoerd Beck, MD 8601 Old Georgetown Road, Bethesda, MD 20814

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signatura
NOV 29 1999	Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Auer, Amelia 14:20 Nov. 26, 1999

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39514

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARTHA BELL
2. Date of Death (Month, Day, Year): DECEMBER 1 1999
3. Time of Death: 10:10 AM
4e. Facility Name (If not institution, give street and number): DOCTORS COMMUNITY HOSPITAL
4b. City, Town, or Location of Death: LANHAM
4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 214-32-9857
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 21, 1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 11616 Duckettown Road
10f. Zip Code: 20719
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Shafer Coleman
18. Mother's Name (First, Middle, Maiden Surname): Mageline Thomas

19a. Informant's Neme/Relationship (Type, Print): Monetta Harvey/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11616 Duckettown Road, Bowie, Maryland 20719

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Memorial Park | Date: 12/05/1999
20c. Location - City or Town, State: Landover, Maryland

21. Signature of Funeral Service Licensee: John A. [illegible]
22. Name and Address of Facility: J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	ANOXIC ENCEPHALOPATHY	3 days
Due to (or as a consequence of): b.	CARDIORESPIRATORY ARREST	3 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.	Myocardial Infarction	3 days
Due to (or as a consequence of): d.	Arteriosclerotic Cardiovascular Disease	4 years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus type I

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul A. DeVore
29c. License number: D01852
29d. Date signed (Month, Day, Year): DECEMBER 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL A. DeVORE MD 4203 QUEENSBURY Rd HYATTSVILLE MD 20781

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999
32. Registrar's Signature: [illegible]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

MARTHA BELL

CR

5

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39515

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lee Emerson Brown

2. Date of Death Month Day Year: Nov 30, 1999

3. Time of Death: 4:30 AM

4a. Facility Name *(If not institution, give street and number)*: Fort Washington Hospital

4b. City, Town, or Location of Death: Fort Washington

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 031 36 3936

6. Sex: 1☐ M 2☐ F — X

7. Age *(In yrs. last birthday)*: 50 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 11, 1949

9. Birthplace *(State or Foreign Country)*: Washington DC

Usual Residence of Decedent

10a. State: MD

10b. County: P .G.

10c. City, Town or Location: Temple Hills

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: Apt. T-2 3302 Huntley Square Drive

10f. Zip Code: 20748

10g. Citizen of What Country?: United States

11. Marital Status: ☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Computer Programmer

16b. Kind of Business/Industry: Federal Government

17. Father's Name *(First, Middle, Last)*: Robert Nelson Brown, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Gladys Wood

19a. Informant's Name/Relationship *(Type, Print)*: Gladys Brown (MOTHER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7520 Earnshaw Drive, Brandywine, MD 20613

20a. Method of Disposition: ☒ 1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Resurrection Cemetery Dec 4,1999

Dete

20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: Kelli R. Patten

22. Name and Address of Facility: Lee Funeral Home,Inc 6633 Old Alexandria Ferry Road, Clinton,Maryland

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)

a. Cardiac Arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last

b. Respiratory Arrest

Due to (or es e consequence of):

c. Pulmonary Embolism

Due to (or as e consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

Heart Failure

Liver Failure

23b. Did tobecco use contribute to the cause of deeth? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: ☒ 1 Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: ☒ 1 Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: ☒ 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D0021833

29d. Date signed *(Month, Day, Year)*: 11-30-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): My Sabet M.D. 11701 Livingston Road #209 Ft. Washington MD

State Registrar

31. Date Filed *(Month, Day, Year)*: DEC 03 1999

32. Registrar's Signature: Brenda B. Harris

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by tha funeral director, page 2 should be detached for use es tha burial-transit

(10)

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39516

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CLIFTON C. BEACHUM
2. Dete of Deeth Month: 11 Day: 24 Year: 99
3. Time of Deeth: 1143
4e. Fecility Neme *(If not institution, give street end number)*: BALTIMORE VA HOSPITAL
4b. City, Town, or Location of Deeth: BALTIMORE
4c. County of Deeth:

Funeral Director

5. Social Security Number: 578-64-4735
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 51 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Yeer)*: May 29, 1948
9. Birthplace *(State or Foreign Country)*: South Carolina

Usuel Residence of Decedent

10e. State: Maryland
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 5214 Bowleys Lane
10f. Zip Code: 21206
10g. Citizen of What Country?: U.S.A.
11. Maritel Stetus: 1 [ ] Never Merried 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: 3/22/68 - 12/10/73
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* Black
15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): ; College (1-4or 5+): 1yr.
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Plasterer
16b. Kind of Business/Industry: Private
17. Fether's Neme *(First, Middle, Last)*: Clifton Beachum, Sr.
18. Mother's Neme *(First, Middle, Maiden Surname)*: Eugenia Nelson
19a. Informent's Neme/Reletionship *(Type, Print)*: Peggy A. Pearsall/Sister
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 905 Finch Drive, Landover, Maryland 20785
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Plece of Disposition *(Neme of cemetery, cremetory or other plece)*: Maryland Veterans Cemetery — Dete: 11/03/1999
20c. Locetion - City or Town, Stete: Cheltenham, Maryland
21. Signeture of Funeral Service Licensee:
22. Neme end Address of Fecility: J.B. JENKINS FUNERAL HOME, 7474 Landover Road, Landover, Maryland 20785

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert failure. List only one cause on eech line. — Approximete Interval Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in death)
e. MYOCARDIAL INFARCTION
Due to (or es e consequence of):
Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last
b. CORONARY ARTERY DISEASE
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobecco uee contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings eveilable prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospitel: 1 [X] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Locetion *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete end plece, and due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, dete and plece, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier:
29c. License number: 12447
29d. Dete signed *(Month, Dey, Yeer)*: 11/24/99

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Amir Monifar, MD 22 S. Greene Street Dept. of Surgery 21201

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: NOV 30 1999
32. Registrer's Signeture:

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NOV 3 0 1988

99-7093-031
JAD
Otis Baker

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39517

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Otis Ray Baker, Jr.
2. Data of Death — Month, Day, Year: November 27, 1999
3. Time of Death: 14:15
4a. Facility Name (If not institution, give street and number): 11212 Greenwatch Way
4b. City, Town, or Location of Death: North Potomac
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 213 54 7206
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 50 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Oct 12, 1949
9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedant

10a. State: MD
10b. County: P.G.
10c. City, Town or Location: Capitol Heights
10d. Inside City Limits: 1 [ ] Yas 2 [XX] No
10e. Street and Number: 1211 Rally Ave
10f. Zip Code: 20743
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Nevar Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yas 2 [X] No — If Yas, Giva Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 [ ] Yes 2 [XX] No Specify:
14. Race - Amarican Indian, Black, Whita, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4or 5+):
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Retail Produce Mgr.
16b. Kind of Business/Industry: Grocery

17. Fathar's Nama (First, Middle, Last): Otis Ray Baker, Sr.
18. Mother's Nama (First, Middle, Maiden Surname): Josephine Allan

19a. Informant's Name/Ralationship (Type, Print): Glenn Baker (SON)
19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6896 Jockey Club Lane, Haymarket, VA 20165

20a. Mathod of Disposition: 1 [XX] Burial 2 [ ] Cremation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Othar (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lovettsville Cemetery — Date: Dec 3, 1999
20c. Location - City or Town, Stata: Lovettsville, Virginia

21. Signatura of Funaral Sarvice Licensee: [signature]
22. Nama and Address of Facility: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

Physician /Medical Examiner

23a. Part I. Enter the disaasa, or complications that caused tha death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List *only ona* cause *on* aach lina. — Approximate Interval Between Onset and Death

Immediata Causa (Final disease or condition resulting in death): a. Hypertensive atherosclerotic cardiovascular disease
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Causa (Disaasa or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Ware autopsy findings available prior to completion of cause of death? 1 [X] Yas 2 [ ] No

25. Was case referred to medical examinar? [XX] Yas 2 [ ] No

26. Place of Death (Check only one) — Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Homa 5 [ ] Residence 6 [XX] Othar (Specify) (Scene)

27. Mannar of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifiar (Check only one): 1 [ ] **Certifying Physician:** To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [XX] **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at the fima, date and place, and due to tha cause(s) and mannar stated.
29b. Signatura and titla of cartifier: [signature]
29c. License number: O.C.M.E.
29d. Data signed (Month, Day, Year): November 28, 1999

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print): David R Fowler, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year): NOV 30 1999
32. Registrar's Signatura: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

(15)

NOV 3 0 1939

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39518

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Virginia R. Brandt

2. Date of Death (Month, Day, Year): Nov. 25 1999

3. Time of Death: 7:45 A.M.

4a. Facility Name *(If not institution, give street end number)*: Larking-Chase Nursing Home

4b. City, Town, or Location of Death: Bowie

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 218 66 8809

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 11,1910

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Bowie

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 3109 Shield Lane

10f. Zip Code: 20715

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Fether's Neme *(First, Middle, Last)*: Alfred Leroy Robinson

18. Mother's Name *(First, Middle, Maiden Surneme)*: Agnes Eiker

19a. Informant's Name/Reletionship *(Type, Print)*: Cordelia Johnson Friend

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 12407 Stafford Lane Bowie Maryland 20715

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removel from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Plece of Disposition *(Neme of cemetery, crematory or other piece)*: Lakemont Memorial Gardens | Date: Nov. 30, 1999

20c. Location - City or Town, Stete: Davidsonville MD

21. Signature of Funeral Service Licensee: Todd Liller

22. Neme end Address of Fecility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

Immediete Cause (Final diseese or condition resulting in death)

a. RESPIRATORY FAILURE — Due to (or es a consequence of): — one-day.

Sequentielly list conditions, if any, leading to immediete ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest

b. END-STAGE COPD. — Due to (or es a consequence of):

c. — Due to (or as e consequence of):

d.

Part II. **Other significent conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.: CACHEXIA, BRONCHITIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth *(Check only one)*: Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of exemination end/or investigetion, in my opinion, deeth occurred at the time, date end plece, and due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier: [signature]

29c. License number: D-34525

29d. Dete signed *(Month, Dey, Yeer)*: 11-25-1999

30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print): S J RAO, MD - 4000 Mitchellville Road, #220, Bowie MD 20716.

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: NOV 30 1999

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

15

NOV 3 0 1959

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39519

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edythe G. Beaman

2. Date of Death (Month, Day, Year): November 27, 1999

3. Time of Death: 2:45AM

4a. Facility Name (If not institution, give street and number): Larkin Chase Nursing Home

4b. City, Town, or Location of Death: Bowie

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 214-03-4856

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 13, 1914

9. Birthplace (State or Foreign Country): Baltimore, Md.

Usual Residence of Decedent

10a. State: Delaware

10b. County: Sussex

10c. City, Town or Location: Selbyville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 29 River Birch Dr.

10f. Zip Code: 19975

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Travelers Insurance

17. Father's Name (First, Middle, Last): Norbert W. Dorsey

18. Mother's Name (First, Middle, Maiden Surname): Viola W. Brown

19a. Informant's Name/Relationship (Type, Print): Blake R. Fohl/Personal Rep.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as item 10

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory — Date: 11/27/99

20c. Location - City or Town, State: Alexandria, Va.

21. Signature of Funeral Service Licensee: George P. Kalas Jr.

22. Name and Address of Facility: George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Atherosclerotic Cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gloria Burns, MD

29c. License number: D0055227

29d. Date signed (Month, Day, Year): November, 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 3001 Hospital Dr. Cheverly, Maryland Gloria Burns, M.D.

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999

32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39520

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Burdette Harvey Buck

2. Date of Death: Month November Day 23 Year 1999

3. Time of Death: 6:58pm

4a. Facility Name (If not institution, give street and number): Doctors' Community Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 203 12 3383

6. Sex: 1☐ M 2☐ F — xx

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 23, 1923

9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Lanham

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 9113 Tuckerman Street

10f. Zip Code: 20706

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates: 41-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Guidance Counselor

16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Burdette Buck

18. Mother's Name (First, Middle, Maiden Surname): Mildred Harvey

19a. Informant's Name/Relationship (Type, Print): Betty Buck Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9113 Tuckerman Street Lanham Maryland 20706

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Lakemont Memorial Gardens — Date: Nov. 29, 1999

20c. Location - City or Town, State: Davidsonville Maryland

21. Signature of Funeral Service Licensee: Todd Liller

22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Congestive Heart Failure	6 months
Due to (or as a consequence of): b.	Myocardial Infarction	6 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Coronary Artery Disease	years
Due to (or as a consequence of): d.	Tobacco Use	years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S. Chatrathi

29c. License number: 52119

29d. Date signed (Month, Day, Year): 11-24-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sridhar Chatrathi 8100 GoodLuck Road Suite 302 Lanham Md 20706

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999

32. Registrar's Signature: [signature]

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Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Burdette Harvey Buck

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39521

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Bernard Bernstein

2. Dete of Deeth (Month, Day, Yeer): November 26, 1999

3. Time of Deeth: 5:40 AM

4e. Fecility Neme (If not institution, give street end number): Doctor's Community Hospital

4b. City, Town, or Location of Deeth: Lanham

4c. County of Deeth: Prince George

Funeral Director

5. Sociel Security Number: 267-24-5797

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. lest birthdey): 73 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): Jan. 22, 1926

9. Birthplece (Stete or Foreign Country): New Jersey

Usuel Residence of Decedent

10a. Stete: Md.

10b. County: Prince george

10c. City, Town or Location: Seabrook

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 9804 Justina Court

10f. Zip Code: 20706

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - Americen Indien, Bleck, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grede completed): Elementery/Secondery (0-12): 12; College (1-4or 5+): 2

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Mailing Requirements Clerk

16b. Kind of Business/Industry: U.S.Post Office

17. Fether's Neme (First, Middle, Last): Juluis Bernstein

18. Mother's Neme (First, Middle, Meiden Surneme): Daisy Binder

19e. Informent's Neme/Reletionship (Type, Print): Helen J.Bernstein

19b. Meiling Address (Street end Number or Ruriel Route Number, City or Town, Stete, Zip Code): 9804 Justina Court Seabrook Md. 20706

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other place): George Washington

Dete: 11-29-99

20c. Locetion - City or Town, Stete: Adelphi Md.

21. Signeture of Funeral Service Licensee: Stanley E. Marcelas Jr.

22. Neme end Address of Fecility: Rendon/Hale Funeral Home 9013 Annapolis Road Lanham Md. 20706

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cerdiec or respiratory errest, shock, or heert feilure. List only one ceuse on each line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Finel disease or condition resulting in deeth)

e. Sepsis — days

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest

b. Hepatoma — Months

Due to (or es e consequence of):

c. liver cirrhosis — Years

Due to (or es e consequence of):

d.

Pert Ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Deeth (Check only one): Hospitel: 1☑ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Locetion (Street end Number or Ruriel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) end manner stated.

29b. Signeture and title of certifier: A. Shaigany

29c. License number: D-17540

29d. Dete signed (Month, Dey, Yeer): 11,27,99

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Dr. A. Shaigany 5632 Annapolis Road Bladensburg Maryland 20710

State Registrar

31. Dete filed (Month, Dey, Yeer): NOV 29 1999

32. Registrer's Signeture: B. Sparks

DHMH 16 Rev 6/95

BERNSTEIN, Bernard

(10)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39522

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Norma Mabel Barrett
2. Date of Death (Month, Day, Year): November 23, 1999
3. Time of Death: 9:00 am
4a. Facility Name (If not institution, give street and number): Collington Episcopal Life Care Community
4b. City, Town, or Location of Death: Mitchellville
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-12-1843
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 30, 1920
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Mitchellville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10450 Lottsford Road
10f. Zip Code: 20721
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrative Secretary
16b. Kind of Business/Industry: Giant Food

17. Father's Name (First, Middle, Last): Frank F. Freeman
18. Mother's Name (First, Middle, Maiden Surname): Bessie B. Kelly

19a. Informant's Name/Relationship (Type, Print): Robert P. Barrett (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7550 Brentland Road, Welcome, Maryland 20693

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery
Date: 12/03/99
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: ▶ Claudette J. Gasch
22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acute Myocardial Infarction — Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Peripheral Vascular Disease; Vascular dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner steted.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D20079
29d. Dete signed (Month, Day, Year): November 23, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Don H. Yablonowitz, M.D. 7404 Executive Place, #502, Seabrook, Maryland 20706

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

NOV 3 0 1988

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39523

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARGUERITE L. BUTLER

2. Date of Death Month / Day / Year: NOVEMBER 19, 1999

3. Time of Death: 0850 AM

4a. Facility Name *(If not institution, give street and number)*: 5805 42nd Avenue Apt # 318

4b. City, Town, or Location of Death: HYATTSVILLE

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 578-70-9591

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 22, 1918

9. Birthplace *(State or Foreign Country)*: Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5805 42nd Avenue, #318

10f. Zip Code: 20781

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: N/A

17. Father's Name *(First, Middle, Last)*: William E. Butler

18. Mother's Name *(First, Middle, Maiden Surname)*: Lucille Barbour

19a. Informant's Name/Relationship *(Type, Print)*: Louise B. King - Sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5209 13th Street N.W. Washington DC 20011

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory

Date: 11-26-99

20c. Location - City or Town, State: Alex., Virginia

21. Signature of Funeral Service Licensee: Julia P. Marshall

22. Name and Address of Facility: Marshall's Funeral Home, Inc. 4308 Suitland Road, Suitland, Maryland 20746

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Date of Injury *(Month, Day, Year)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mario F. Golie JR MD

29c. License number: 033954

29d. Date signed *(Month, Day, Year)*: NOVEMBER 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARIO F. GOLIE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 29 1999

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ADA 3 8 1933

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39524

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Juanita Winters Bachtell
2. Date of Death (Month, Day, Year): December 5 1999
3. Time of Death: 2138
4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 216-03-2028
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 95 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 5, 1904
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Washington
10c. City, Town or Location: Smithsburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 8 Pennsylvania Ave.
10f. Zip Code: 21783
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Home

17. Father's Neme *(First, Middle, Last)*: Ardie W. Winters
18. Mother's Name *(First, Middle, Maiden Surname)*: Shirdie E. Honodel

19a. Informent's Neme/Reletionship *(Type, Print)*: Betty B. Kelly (Daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8925 SE 58th Mercer Island, Wa 98040

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Smithsburg Cemetery — Date: Dec. 8, 1999
20c. Location - City or Town, Stete: Smithsburg, Md.

21. Signature of Funeral Service Licensee: Dennis R. Davis
22. Name end Address of Facility: Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. — Approximate Interval Between Onset and Deeth

Immediate Cause (Finel disease or condition resulting in death): e. Pneumonia — 2-3 days
Due to (or as a consequence of): b. Cerebrovascular Accident — 2-3 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or es e consequence of): c.
Due to (or as e consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Arteriosclerotic Cardiovascular Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated.

29b. Signeture and title of certifier
29c. License number: D18019
29d. Date signed *(Month, Day, Year)*: DEC 6, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Datta 334 Mill St. Hag. Md.

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 07 1999
32. Registrar's Signature: P. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Bachtell, Juanita E VA

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39525

Certificate of Death

Reg. No.

Emerson Morris Bowman
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Emerson Morris Bowman
2. Date of Death Month Day Year: Dec. 4, 1999
3. Time of Death: 1715
4a. Facility Name *(If not institution, give street end number)*: Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 217-18-7138
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 9, 1924
9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.
10b. County: Washington
10c. City, Town or Location: Boonsboro
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: Lakin Ave. Ext.
10f. Zip Code: 21713
10g. Citizen of What Country?: U.S.A.
11. Meritel Stetus: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: White
15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Maintenance
16b. Kind of Business/Industry: Park Service
17. Fether's Neme *(First, Middle, Last)*: Morris Bowman
18. Mother's Neme *(First, Middle, Maiden Sumeme)*: Naomi F. Bowman
19e. Informent's Name/Reletionship *(Type, Print)*: David Clark (Nephew)
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: P.O. Box 192 Inwood, WV 25428
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Plece of Disposition *(Name of cemetery, cremetory or other piece)*: Pleasant Valley Cemetery
Dete: Dec. 8, 1999
20c. Location - City or Town, Stete: Smithsburg, Md.
21. Signature of Funeral Service Licensee: Dennis K. Davis
22. Neme end Address of Facility: Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line. — Approximete Interval Between Onset end Death

Immediete Cause (Finel diseese or condition resulting in death)
a. Cerebrovascular ischemia
Due to (or es e consequence of):
b. accelerated Hypertension
Sequenfially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last
Due to (or as e consequence of):
c. atherosclerotic cardiovascular disease
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.
Oropharyngeal neoplasm
emphysema

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings aveilable prior fo completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Menner of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physicien**: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as steted. 2 [ ] **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) and menner stated.
29b. Signature and title of certifier: George C. Newman III, Ph.D., M.D.
29c. License number: D 17591
29d. Date signed *(Month, Dey, Year)*: 12/6/99
30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): George C. Newman II Dr Newman 11110 Medical Campus Rd Hag. Md.

State Registrar

31. Dete filed *(Month, Dey, Year)*: DEC 07 1999
32. Registrer's Signeture: Geneva G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39526

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Emma Balducci
2. Date of Death (Month, Day, Year): Dec 1st 1999
3. Time of Death: 7:40AM
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 212-24-9528
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 1, 1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11200 Stonecroft Court
10f. Zip Code: 21740
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: home

17. Father's Name (First, Middle, Last): William Keil
18. Mother's Name (First, Middle, Maiden Surname): Ella Marie Dorsey

19a. Informant's Name/Relationship (Type, Print): Nancy E. Angle Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13290 Waterloo Road Waynesboro, Pennsylvania 17268

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens Of Faith Cemetery | Date: 12/6/99
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Gerald N. Minnich
22. Name and Address of Facility: Gerald N. Minnich Funeral Home, 305 N. Potomac Street Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Adenocarcinoma of the Colon with widespread metastases — one year

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Robert Brull MD Personal Physician
29c. License number: D04359
29d. Date signed (Month, Day, Year): Dec 1st 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Brull 1459 Potomac Ave Hagerstown, Md 21742

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39527

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Lyle Barron

2. Date of Death: Month November Day 29 Year 1999

3. Time of Death: 4:25 P.M.

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington County

Funeral Director

5. Social Security Number: 232-10-7419

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 86 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 6, 1913

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 18514 Orchard Hills Parkway

10f. Zip Code: 21742

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 10; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Walter Lee Barron

18. Mother's Name (First, Middle, Maiden Surname): Vadna Ruth Bowers

19a. Informant's Neme/Relationship (Type, Print): Evelyn A. Barron/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18514 Orchard Hills Parkway, Hagerstown, MD 21742

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other piece): Rosedale Cemetery

Date: Dec. 2

20c. Location - City or Town, State: Martinsburg, WV

21. Signature of Funeral Service Licensee: Kelly A. Zimmerman

22. Name and Address of Facility: Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Ventricular Fibrillation due to — hrs

Due to (or as a consequence of):
b. Severe Coronary Artery Disease — Yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred et the time, date and piaca, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rodney L. Hyde MD

29c. License number: 30 61741

29d. Date signed (Month, Day, Year): 11-30-99

30. Name and address of person who completed cause of death (Item 23a) (Type/Print): E. R. Loadholt MD 387 Pasture c/o David, Hagerstown MD 21742

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Barron, William Lyle

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39528

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cecelia Lorraine BLOYER
2. Date of Death (Month, Day, Year): November 28, 1999
3. Time of Death: 1:45 PM
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 218-38-2043
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 57 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar.21,1942
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1037 Spruce Street
10f. Zip Code: 21740
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): operator
16b. Kind of Business/Industry: answering service
17. Father's Name (First, Middle, Last): Andrew White
18. Mother's Name (First, Middle, Maiden Surname): Thelma Spence
19a. Informant's Name/Relationship (Type, Print): Terri L. Miller - daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14719 Clear Spring, Maryland, Williamsport, Md.21795
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Rose Hill Cemetery
Date: 12-1-1999
20c. Location - City or Town, State: Hagerstown,Maryland
21. Signature of Funeral Service Licensee: Scott M Minnich
22. Name and Address of Facility: MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Trauma — 12 days
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Multiple Sclerosis

Nicotine Abuse

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year): November 16, 1999
28b. Time of Injury: 6:15 PM
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: fell down steps at home
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): At home - Spruce Street
28f. Location (Street and Number or Rural Route Number, City or Town, State): 1037 Spruce St. Hagerstown MD

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Edward W. Ditto
29c. License number: D01062
29d. Date signed (Month, Day, Year): November 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edward W. Ditto, III, M.D. 217 W. Washington St. Hagerstown, MD 21740

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

99-7103-043
B.K.S

JOHN DENNIS BOWMAN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39529

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: JOHN DENNIS BOWMAN
2. Data of Death Month Day Year: NOV. 27, 1999
3. Time of Death: 1:15 PM
4a. Facility Nama *(If not institution, giva street and number)*: 20029 JEFFERSON BLVD.
4b. City, Town, or Location of Death: HAGERSTOWN
4c. County of Deeth: WASHINGTON

Funeral Director

5. Social Sacurity Number: 219-52-1602
6. Sex: 1☒M 2☐F
7. Aga *(In yrs. last birthday)*: 50 Yrs. If Under 1 Yaar: Months / Days; If Undar 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 24,1949
9. Birthplaca *(Stata or Foraign Country)*: Pennsylvania

Usual Residence of Decedant

10a. State: Maryland
10b. County: Washington Co.
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☐Yas 2☒No
10e. Street and Number: 20029 Jefferson Blvd.
10f. Zip Code: 21742
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☒Never Marriad 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Giva Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.): 1☐Yas 2☒No *Specify:*
14. Raca - Amarican Indian, Black, White, atc. *Specify:* White
15. Decedent's Education *(Specify only highast grada complatad)*: Elamentary/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT use retired)*: Salesman
16b. Kind of Business/Industry: Waterproofing Company
17. Father's Nema *(First, Middle, Last)*: George T. Bowman
18. Mother's Name *(First, Middle, Maiden Sumama)*: Betty Ann Bulebosh
19a. Informant's Name/Reletionship *(Type, Print)*: Janet K. Bowman / Sister
19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 12032 Pioneer Drive Smithsburg,Maryland 21783
20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Ramovel from Stata 4☐Donetion 5☐Othar *(Specify)*
20b. Place of Disposition *(Name of cematery, crematory or othar place)*: Rest Haven Cemetery
Data: Dec. 1,1999
20c. Location - City or Town, Steta: Hagerstown,Maryland
21. Signature of Funaral Sarvice Licensee: Douglas A. Fiery
22. Nama and Address of Facility: Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown,Maryland 21742

Physician /Medical Examiner

23e. Part1. Entar the disaasa, or complications that caused tha daath. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only ona causa on aach line.

Approximate Interval Between Onset and Death

Immediata Cause (Final disaasa or condition resulting in death): a. Intracral Gunshot Wound

Dua to (or as a consequence of):

Sequentially list conditions, if any, leeding to immadiata causa. Enter Underlying Cause (Diseasa or Injury thet initiated evants resulting in death) Last:
b.
Due fo (or as a consequence of):
c.
Dua fo (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Wes an autopsy performed? 1☑Yas 2☐No

24b. Wara autopsy findings available prior to completion of cause of death? 1☑Yes 2☐No

25. Wes casa rafarred to medical examinar? XX Yas 2☐No

26. Placa of Death *(Check only ona)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Homa XX☑Rasidanca 6☐Othar *(Specify)*

27. Manner of Death: 1☐Naturel 2☐Accident 3☑Sulcide 4☐Homicide 5☐Panding investigetion 6☐Could not be datarmined

28a. Dete of Injury *(Month, Day Year)*: 11-27-99
28b. Tima of Injury: unknown
28c. Injury at Work? 1☐Yas 2☑No
28d. Describe how injury occurred: Subject shot self
28e. Piece of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*: Residence
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*: 20029 Jefferson Blvd

29a. Cartifiar *(Check only one)*: 1☐ **Certifying Physician:** To tha best of my knowledga, death occurred at the time, date and plece, end due to the cause(s) and mannar as stated. XX **Medical Examiner:** On tha basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signetura end titla of cartifiar:
29c. Licensa number: O.C.M.E
29d. Data signed *(Month, Day, Year)*: NOV. 28, 1999

30. Name and address of person who complated causa of daath (Item 23a) (Type, Print): David R Farber 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed *(Month, Day, Year)*: NOV 3 0 1999
32. Registrar's Signatura: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requiras that the death certificata be axecuted within 24 hours aftar death.
To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

99-6996-025
CJ
Wilhelm Burger

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39530

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILHELM HORST BURGER
2. Date of Death: Month November Day 21 Year 1999
3. Time of Death: 12:35 PM.
4a. Facility Name (If not Institution, give street and number): #9 Emerson Street
4b. City, Town, or Location of Death: Aberdeen
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 212-50-2337
6. Sex: [X] M [ ] F
7. Age (In yrs. last birthday): 60 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): April 14, 1939
9. Birthplace (State or Foreign Country): Germany

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Aberdeen
10d. Inside City Limits: [X] Yes [ ] No
10e. Street and Number: 9 Emerson Street
10f. Zip Code: 21001
10g. Citizen of What Country?: Germany

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: u/k
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter
16b. Kind of Business/Industry: Construction
17. Father's Name (First, Middle, Last): Joseph (nmn) Burger
18. Mother's Name (First, Middle, Maiden Surname): Barbara Josephine Wild
19a. Informant's Name/Relationship (Type, Print): Brigitte Maria Feltz, Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6 Wilson Avenue, Aberdeen, Maryland 21001
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Othar (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Hilltop Service Corporation
Date: 12/2/99
20c. Location - City or Town, Stata: Towson, Maryland
21. Signature of Funeral Service Licensee: Holly K. McComas
22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on eech line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic cardiovascular disease
Due to (or as e consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due fo (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.: Diabetes

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Ware autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examinar? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Othar (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending invastigetion 6 [ ] Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurat Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the tima, date and place, and dua to tha cause(s) and mannar as stated. 2 [X] **Medical Examiner**: On the basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, data and place, and due to tha cause(s) and manner stated.

29b. Signeture and title of certifier: Stephen S. Radentz MD
29c. License number: O.C.M.E.
29d. Data signed (Month, Day, Year): November 22, 1999
30. Name and address of person who complated cause of death (Item 29a) (Type, Print): Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 02 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

SR
10+1

99-7132-033
JAD

David S. Bacon
AMEND ITEMS: #23 PART I, II, 27, 28A-E PER MEO G779 1-5-2000 WR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39531

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
DAVID S. BACON	November 29, 1999	16:45

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2003 Erie St. Apt. 2	Adelphi	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-48-9465	1☒M 2☐F	50 Yrs.			Nov. 30, 1948	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Pr. Geo.	Hyattsville	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2003 Erie Street	20783	U.S.A.

11. Meritel Stetus	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, Whita, atc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yas, Giva Year or Detes:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Busines/Industry
Elemantary/Secondary (0-12)	College (1-4or 5+)		
12th		Warehouse Foreman	U.S. Government

17. Father's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Sumeme)
Charles T. Bacon, Sr.	Mary E. Powell

19e. Informent's Name/Raletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
Gregory A. Bacon (Brother)	18474 Brooke Rd., Sandy Spring, MD 20860

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, Steta
☒Burial 2☐Cremetion 3☐Removal from State 4☐Donation 5☐Other (Specify)	Gate of Heaven Cem.	12/7/99	Silver Spring, MD

21. Signeture of Funeral Service Licensee	22. Name and Address of Facility
George R. Snowden	SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one causa on aech line.

Approximeta Interval Between Onset end Death

Immediate Cause (Final diseesa or condition resulting in deeth)
a. HEAD INJURIES

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury thet Initieted avents resulting in death) Last
b.

Due to (or es a consequence of):
c.

Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ALCOHOLISM

CIRRHOSIS

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Wes case referred to medical exeminer?	26. Place of Death (Check only one)	
XXX☒Yas 2☐No	Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home XXX☒Residence 6☐Other (Specify)

27. Mennar of Death	28a. Dete of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Naturel 2☒Accident 3☐Suicide 4☐Homicida 5☐Pending investigetion 6☐Could not be determined	Found: 11-29-99	UNKNOWN M	1☐Yes 2☒No	SUBJECT FELL & STRUCK HEAD

28e. Piece of Injury - At home, ferm, street, factory, office building, atc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
RESIDENCE	2033 ERIE ST. ADELPHI, MD

29e. Certifier (Check only one) 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
XXX☒ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier	29c. License number	29d. Dete signed (Month, Day, Year)
Stephen R. Radentz, MD	O.C.M.E.	November 30, 1999

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Yeer)	32. Registrar's Signature
DEC 03 1999	James G. Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39532

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Michael Hamilton Baker
2. Date of Death (Month, Day, Year): November 24, 1999
3. Time of Death: 8:03 PM
4a. Facility Name (If not institution, give street and number): 4300 Glenrose Street
4b. City, Town, or Location of Death: Kensington
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-58-6548
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 53 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 3, 1946
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4300 Glenrose Street
10f. Zip Code: 20895
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): - ; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Tree Trimmer
16b. Kind of Business/Industry: Tree Trimming Company

17. Father's Name (First, Middle, Last): Ellis Thomson Baker, III
18. Mother's Name (First, Middle, Maiden Surname): Margaret Ellen Bretz

19a. Informant's Name/Relationship (Type, Print): M. Laurie Baker/ Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4300 Glenrose Street, Kensington, MD 20895

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.
Date: Nov. 26, 1999
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: [signature] MD689
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cirrhosis	6 years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D04766
29d. Date signed (Month, Day, Year): November 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Daniel Rosenblum, M.D. 10400 Connecticut Avenue, #606, Kensington, MD 20895

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

is

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39533

AMEND ITEMS 1,14,17,18 PER MD & FH G778 *Certificate of Death* 12/21/99 Reg. No. AH

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Balram ~~Balram~~

2. Date of Death Month Day Year: November 28, 1999

3. Time of Death: 2:00 AM

4a. Facility Name (If not institution, give street and number): Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 216-13-3375

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Yaar: Months / Days | If Undar 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Nov 26, 1926

9. Birthplaca (State or Foreign Country): Guyana

Usual Residence of Decedent

10a. Stata: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Insida City Limits: 1☐Yas 2☒No

10e. Street and Number: 12220 Bond St

10f. Zip Code: 20902

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Nevar Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 1☐Yas 2☒No Specify:

14. Race - Amaricen Indian, Black, Whita, atc. Specify: INDIAN ~~Black~~

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer

16b. Kind of Businass/Industry: Self Employed

17. Fathar's Nama (First, Middle, Last): ~~Sooknanen (Unobtainable)~~ SOOKNANAN

18. Mother's Nama (First, Middle, Maiden Surname): ~~Unobtainable~~ MEGHIA

19a. Informant's Name/Ralationship (Type, Print): Awadnarine Balram (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19001 Old Baltimore Rd, Brookeville, MD 20833

20a. Mathod of Disposition: 1☒Burial 2☐Cremation 3☐Removal from Stata 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery | Dete: Dec 1

20c. Location - City or Town, Stata: Silver Spring, MD

21. Signature of Funaral Service Licensee: ▶ Alan J Donnell

22. Nama and Address of Facility: Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on aach lina.

Approximata Intervel Between Onset end Death

Immedieta Causa (Final disaasa or condition resulting in death)
a. Acute Cerebrovascular Accident — 2 Weeks

Due to (or as a consequence of):
b. Hypertension

Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying ceusa given in Part I.: Chronic Renal Failure

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was en autopsy performed? 1☐Yas 2☒No

24b. Ware autopsy findings available prior to complation of causa of death? 1☐Yes 2☐No

25. Was casa rafarred to medical examiner? 1☐Yaa 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Homa 5☐Residence 6☐Othar (Specify)

27. Mennar of Death: 1☒Neturat 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be detarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐Yas 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Cartifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to tha causa(s) and manner as stated. 2☐**Medical Examiner:** On the basis of axamination end/or investigation, in my opinion, daath occurred at tha tima, dete and piece, end due to the ceuse(s) and manner stated.

29b. Signatura and titla of cartifier: ▶ Rahul Gilotra MD

29c. License number: D32417

29d. Data signed (Month, Day, Year): November 28th, 1999

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print): RAHUL GILOTRA M.D. 12016 GEORGIA Avenue Wheaton MD 20902

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requiras that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

ORIGINAL

(#31)
11/29/99 Date Stamp first Reflected Incorrect date 11/26/99
~~Date~~ Incorrect date whited-out + Replaced with correct one -
B. McWilliams

ADH
ROBERT BAREFOOT
99-7078-031

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39534

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert David Barefoot, Jr.

2. Date of Death: Month NOVEMBER Day 26, Year 1999

3. Time of Death: 1349 PM

4e. Facility Name (If not institution, give street and number): SUBURBAN HOSPITAL

4b. City, Town, or Location of Death: BETHESDA

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 217-23-0387

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 16 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 12, 1983

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: NC

10b. County:

10c. City, Town or Location: Kannapolis

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1864 Enochville Road

10f. Zip Code: 28081

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student

16b. Kind of Business/Industry: High School

17. Father's Name (First, Middle, Last): Robert David Barefoot

18. Mother's Name (First, Middle, Maiden Surname): Patrice Blackson

19a. Informant's Name/Relationship (Type, Print): Robert Barefoot

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5123 Waukesha Rd, Bethesda, Md 20816

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): National Crematory

Date: 112999

20c. Location - City or Town, State: Falls Church, VA

21. Signature of Funeral Service Licensee: Thomas E. Hornbaker

22. Name and Address of Facility: Joseph Gawler's Sons, 5130 Wisc. Ave NW, Washington, DC 20016

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

b

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): 11-26-99

28b. Time of Injury: 1245 M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: Driver auto - fixed object collision

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Roadway

28f. Location (Street and Number or Rural Route Number, City or Town, State): 5000 Blk Sangamore

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☒ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier:

29c. License number: OCME

29d. Date signed (Month, Day, Year): NOVEMBER 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler, 111 Penn Street, Baltimore, Maryland 21201

b

State Registrar

31. Date filed (Month, Day, Year): DEC 01 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

ORIGINAL

99-7135-027
B.K.S

JONATHAN BARNEY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39535

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Nama (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
JOHNATHAN R. BARNEY	NOV. 29, 1999	4:30 PM

4a Facility Nama (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
REAR OF 5780 STEVENS FORREST ROAD	COLUMBIA	HOWARD

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-94-8962	1☒ M 2☐ F	19 Yrs.			Mar.20,1980	Maryland

Usual Residence of Decedant

10a. Stata	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Howard	Columbia	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9487 Time Sweep Lane	21045	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, Whita, etc.
1☒ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yas, Giva Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
10th		Warehouseman	Storage & Moving Co.

17. Father's Nama (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Franklin H. Barney, Sr.	Barbara Stanton

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Barbara Dixon (Mother)	9487 Time Sweep Ln., Columbia, MD 21045

20a. Mathod of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Data	20c. Location - City or Town, Stata
1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)	Daisy Church Cem.	12/6/99	Woodbine, MD

21. Signature of Funaral Sarvica Licensee: George K. Snowden

22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

23a. Part1. Enter the diseasa, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart feilure. List only ona cause on each line.

Approximate Interval Between Onset and Death

Immediate Causa (Final disaasa or condition resulting in death)
a. Gunshot Wound of Head
Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immadiata causa. Entar Underlying Cause (Diseasa or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other signficant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was casa refarred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yas 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) AT SCENE

27. Mannar of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Neturel 2☐ Accident 3☐ Suicide 4☒ Homicide 5☐ Panding invastigation 6☐ Could not be determined	11/29/99	4:25 pm M	1☐ Yes 2☒ No	Subject Shot

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify): Street

28f. Location (Street and Number or Rural Route Number, City or Town, State): Forrest Road Howard County, Maryland

29a. Cartifiar (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of cartifiar	29c. License number	29d. Data signed (Month, Day, Year)
Theodore McKingus	O.C.M.E	NOV. 30, 1999

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): THEODORE McKING 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signature
DEC 03 1999	Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

99 99536

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Hedik	Bartels	November 27, 1999	7:20P.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
6303 Hardwood Drive	Lanham	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
228-74-5213	1☐ M 2☒ F	68 Yrs.			Feb.17,1931	Tehran,Iran

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Lanham	1☐ Yes 2☒ No XX

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6303 Hardwood Drive	20706	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	own home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Vazgen Simon	Maro Khatachourian

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Leonard A. Bartels (husband)	same as #10

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Maryland Veterans Cemetery	12/2/1999	Crownsville, MD

21. Signature of Funeral Service Licensee: ▶ Donald V. Borgwardt.

22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Stomach Cancer	Years
Due to (or es a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
Due to (or es a consequence of):		
	c.	
Due to (or es e consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Kenneth Johnson	MD-058246-L	November 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kenneth Johnson, M.D. 8901 Wisconsin Avenue Bethesda, Maryland 20889

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 30 1999	▶ Jenna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39537

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SARAH PELTZ BENCICH

2. Date of Death Month: Nov Day: 24th Year: 1999

3. Time of Death: 4:45 pm

4a Facility Name (If not Institution, give street and number): HEBREW HOME

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-84-7097

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 94 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC. 25, 1904

9. Birthplace (State or Foraign Country): RUSSIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: ROCKVILLE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6121 MONTROSE ROAD

10f. Zip Code: 20852

10g. Citizan of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, Whita, etc. Specify: WHITE

15. Decedent's Education (Specify only highast grade compilated): Elementary/Secondary (0-12): 12; Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: HOME

17. Father's Name (First, Middla, Last): KEVA PELTZ

18. Mothar's Name (First, Middle, Maiden Sumame): HANNAH FLERT

19a. Informant's Name/Ralationship (Type, Print): MARIE A. PRICHARD - DAUGHTER

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 3010 JOSHUA ROAD, LAFAYETTE HILL, PA 19444

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Placa of Disposition (Nama of cemetary, crematory or other placa): FT. LINCOLN CEMETERY

Date: 11-29-99

20c. Location - City or Town, State: BRENTWOOD, MARYLAND

21. Signature of Funeral Servica Licensee: Anthony S. DiMaggio

22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE., SILVER SPRING, MD 20904

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or haart faiture. List only one cause on each lina.

Approximata Intarval Batween Onsat and Death

Immediata Cause (Final disaasa or condition rasulting in daath): a. pneumonia

Dua to (or as a consaquenca of):

Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disaasa or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Othar significant conditions** contributing to death but not rasulting in the underlying causa givan in Part I.

coronary artery disease

diabetes congestive heart failure

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of daath? 1☐ Yes 2☐ No

25. Was case rafarrad to medical examiner? 1☐ Yes 2☒ No

26. Place of Daath (Chack only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Other (Spacify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be daterminad

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Cartifiar (Check only one) 1☒ **Certifying Phyaician**: To the best of my knowledga, daath occurred at tha time, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medtcal Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifiar: Consuelo Arranz

29c. Licansa number: D:44907

29d. Data signed (Month, Day, Year): Nov 24th 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 6121 Montrose Ave, Rockville MD CONSUELO ARRANZ, MD 20852

State Registrar

31. Data filed (Month, Day, Year): DEC 02 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Bencich, Sonah

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39538

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROBERT JOEL BERMOWITZ
2. Data of Death — Month: 11 Day: 24 Year: 99
3. Time of Death: 2159
4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 094.32.7119
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 58 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 01.22.1941
9. Birthplace *(State or Foreign Country)*: NY

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 101 WATKINS POND BLVD #406
10f. Zip Code: 20850
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): ; College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: METEOROLOGIST
16b. Kind of Business/Industry: FEDERAL GOVERNMENT

17. Father's Name *(First, Middle, Last)*: LOUIS BERMOWITZ
18. Mother's Name *(First, Middle, Maiden Surname)*: TILLIE LIPSTEIN

19a. Informant's Name/Relationship *(Type, Print)*: SUSAN BERMOWITZ/WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 101 WATKINS POND BLVD #406, ROCKVILLE, MD 20856

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: JUDEAN MEMORIAL GARDENS
Data: 11.26.99
20c. Location - City or Town, State: OLNEY, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION — MINUTES

Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Date of Injury *(Month, Day Year)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: D37024
29d. Date signed *(Month, Day, Year)*: 11.24.1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. DAVID SROUR, 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MD 20850

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 26 1999
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39539

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sophie Bettien
2. Date of Death: Month NOV Dey 30 Year 1999
3. Time of Death: 2048
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 500-03-8354
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr 23, 1916
9. Birthplace (State or Foreign Country): Missouri

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1316 Fenwick Lane Apt 710
10f. Zip Code: 20910
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrator
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): A. W. Bettien
18. Mother's Name (First, Middle, Maiden Surname): Charlotte May Rigg

19a. Informant's Name/Relationship (Type, Print): LaRue B. Owen / Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14614 Edelmar Drive, Silver Spring, MD 20906

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 12/1/99
20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: James E Dooley
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Acute Intracerebral hemorrhage — 9 hours

Due to (or as a consequence of):
b. Hypertension — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
acute myocardial infarction
gastrointestinal hemorrhage

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.
29b. Signature and title of certifier: Gail J. Povar MD
29c. License number: D46101
29d. Date signed (Month, Day, Year): 11/30/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GAIL J. POVAR, 8700 Georgia Ave, Silver Spring, MD 20910

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999
32. Registrar's Signature: Bruce G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39540

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Melvia E. Black
2. Date of Death Month Day Year: November 25, 1999
3. Time of Death: 9:45 PM
4a. Facility Name *(If not institution, give street and number)*: 14417 Bradshaw Dr
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 226-42-4533
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Mar 28, 1917
9. Birthplace *(State or Foreign Country)*: Washington, DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 14417 Bradshaw Dr
10f. Zip Code: 20905
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Dietician
16b. Kind of Business/Industry: Arlington County Public Schools
17. Father's Name *(First, Middle, Last)*: Roy Miskell
18. Mother's Name *(First, Middle, Maiden Surname)*: Flossie Adrain
19a. Informant's Name/Relationship *(Type, Print)*: Suzanne B. Glancy/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14417 Bradshaw Dr, Silver Spring, MD 20905
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: National Memorial Park
Date: Nov 28
20c. Location - City or Town, State: Falls Church, VA
21. Signature of Funeral Service Licensee: Alan J Dowell
22. Name and Address of Facility: Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cerebrovascular Accident — 2 Days

Due to (or as a consequence of):
Arteriosclerotic Cardiovascular Disease — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and Title of certifier: Benjamin Avrunin, MD
29c. License number: D08381
29d. Date signed *(Month, Day, Year)*: November 26, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Benjamin Avrunin, MD 8111 Prince Philip Dr, Olney, MD 20832

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 26 1999
32. Registrar's Signature: Donna G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

99-7016-031
UNK 99-288
asp
Gary Anthony Bonner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39541

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gary Anthony Bonner
2. Date of Death (Month, Day, Year): NOVEMBER 22 1999
3. Time of Death: 2142
4a. Facility Name (If not institution, give street and number): 7500 BLK LINDBERGH ROAD
4b. City, Town, or Location of Death: Wheaton
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 220-29-1858
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 26 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 21, 1973
9. Birthplace (State or Foreign Country): Jamaica

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 15 Harbor Tree Court
10f. Zip Code: 20879
10g. Citizen of What Country?: USA
11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Baker
16b. Kind of Business/Industry: Food Service
17. Father's Name (First, Middle, Last): Glenroy Bonner
18. Mother's Neme (First, Middle, Maiden Surname): Jestina Pinnock
19a. Informant's Name/Relationship (Type, Print): Jestina Pinnock/ Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1909 Tree Top Lane Apt 21, Silver Spring, MD 20904
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: Nov 29 1999
20c. Location - City or Town, State: Silver Spring, MD
21. Signature of Funeral Service Licensee: Robert E Ramsey
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. (Approximate Interval Between Onset and Death)

Immediete Cause (Final diseese or condition resulting in death)
a. Multiple Gunshot Wounds
Due to (or as a consequence of):
b. and Blunt Force Injuries
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as e consequence of):
c. OF Head
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) SCENE
27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year): 11/22/99 (Found)
28b. Time of Injury: 2100 (Found) M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Subject Shot and Assaulted
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Parking lot (Found)
28f. Location (Street and Number or Rural Route Number, City or Town, State): 7500 Lindbergh Rd ; Wheaton, Md

29a. Certifier (Check only one) 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) and manner stated.
29b. Signature end title of certifier: Wayne Melnick MD
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): NOVEMBER 23,1999
30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print): MAYNARD S. KOLSH 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year): NOV 29 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39542

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARION R. BROCKMAN
2. Date of Death (Month, Day, Year): NOVEMBER 30, 1999
3. Time of Death: 3:59PM
4a. Facility Name (If not institution, give street and number): 1509 GLEASON STREET
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 240 16 1338
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOVEMBER 20, 1921
9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1509 GLEASON STREET
10f. Zip Code: 20902
10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No. If Yes, Give Year or Dates: 5/1/45 – 7/31/46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FLUID SPECIALIST
16b. Kind of Business/Industry: N.I.S.T. US GOVERNMENT

17. Father's Name (First, Middle, Last): HENRY BROCKMAN
18. Mother's Name (First, Middle, Maiden Surname): BELLE WINTERS

19a. Informant's Name/Relationship (Type, Print): SALLIE BROCKMAN/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1509 GLEASON STREET, SILVER SPRING, MD 20902

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): FT. LINCOLN CREMATORY | Date: 12/1/99
20c. Location - City or Town, State: BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME 11800 NEW HAMPSHIRE AVE., SILVER SPRING, MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SMALL CELL GASTRIC CANCER
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. CORONARY ARTERY DISEASE
Due to (or as a consequence of):
c. DIABETES MELLITUS
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D18813
29d. Data signed (Month, Day, Year): 12/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 10201 Georgia Ave Silver Spring MD 20902

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999
32. Registrar's Signature: [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1218

96-6988-033

DAMIEN G. BROWN

Amend #21, 11/30/99, BMW, Montg. Co.
Amend #10a,b, 11/29/99, BMW, Montg Co.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39543

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DAMIEN GERARD BROWN

2. Date of Death (Month, Day, Year): NOVEMBER 20, 1999

3. Time of Death: 11:50 PM

4a. Facility Name (If not institution, give street and number): 7622 ERICA LANE

4b. City, Town, or Location of Death: LAUREL

4c. County of Death: PRINCE GEORGES ~~PRINCE GEORGES~~

Funeral Director

5. Social Security Number: 578-94-9282

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 26 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 24, 1973

9. Birthplace (State or Foreign Country): Washington dc

Usual Residence of Decedent

10a. State: ~~DC~~ MD

10b. County: ~~N/A~~ P.G.

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 14107 Bramble Lane # 204

10f. Zip Code: 20708

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cashier

16b. Kind of Business/Industry: Retail

17. Father's Name (First, Middle, Last): Marshall J. Anderson

18. Mother's Name (First, Middle, Meiden Surname): Juanita Brown Thompson

19a. Informent's Name/Reletionship (Type, Print): Mother Juanita Brown Thompson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3551 55th Ave # 3, Bladensburg Md 20784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Forest Hill

Date: 11/27/99

20c. Location - City or Town, State: Clinton, MD

21. Signature of Funeral Service Licensee: Raymond Chan R. N. Horton CC-0349

22. Name and Address of Facility: R.N. Horton Co. Morticians Inc, 600 Kennedy St, NW Washington, DC 20011

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Gunshot Wound of Head

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) SCENE

27. Manner of Death: 1☐ Neturel 2☐ Accident 3☐ Suicide 4☒ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): 11/20/99

28b. Time of Injury: 2315 M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: Subject Shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Residence

28f. Location (Street and Number or Rural Route Number, City or Town, State): 7622 Erica La, Laurel, MD

29a. Certifier (Check only one): 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

29b. Signature and title of certifier: Jan Locke MD

29c. License number: OCME

29d. Date signed (Month, Day, Year): NOVEMBER 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

99-7017-031
DDG
FRANCES BROWNE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39544

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANCES R. BROWNE
2. Date of Death (Month, Day, Year): NOVEMBER 22, 1999
3. Time of Death: 2014 PM
4a. Facility Name (If not institution, give street and number): SUBURBAN HOSPITAL
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578 62 1529
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 4, 1919
9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3005 So. Leisure World Blvd.#514
10f. Zip Code: 20906
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Public School Administrator
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Albert Raymond
18. Mother's Name (First, Middle, Maiden Surname): Ruth Molsby

19a. Informant's Name/Relationship (Type, Print): Vincent J. Browne Jr. (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1512 Castle Cliff Pl.,Silver Spring, MD. 20904

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: 11/29/99
20c. Location - City or Town, State: Silver Spring,MD.

21. Signature of Funeral Service Licensee: Marvin E. Heath
22. Name and Address of Facility: McGuire Funeral Service Inc. 7400 Georgia Ave.,N.W.,Washington, D.C. 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MULTIPLE INJURIES
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? ☒ Yes 2☐ No

25. Was case referred to medical examiner? ☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): 11-22-99
28b. Time of Injury: 1815 PM
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: DRIVER OF CAR IN IMPACT WITH A TREE
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): ROADWAY
28f. Location (Street and Number or Rural Route Number, City or Town, State): GEORGIA AVENUE AND NEW HAMPSHIRE AVENUE MONT. CO.

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Theodore M. King M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): NOVEMBER 23, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999
32. Registrar's Signature: Jenna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39545

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY ELLEN BUTLER

2. Date of Death (Month, Day, Year): NOV. 25, 1999

3. Time of Death: 11:17PM

4a. Facility Name (If not institution, give street and number): WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: TAKOMA PARK

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 579-11-7221

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 13 1929

9. Birthplace (State or Foreign Country): Liberia

Usual Residence of Decedent

10a. State: Md.

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3612 Bel Pre Road #13

10f. Zip Code: 20906

10g. Citizen of What Country? Liberia

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): John H. Ricks

18. Mother's Name (First, Middle, Maiden Surname): Florence Dennis

19a. Informant's Name/Relationship (Type, Print): Phyllis Gardiner/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3748 Capulet Terrace Silver Spring, Md. 20906

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): unknown

Date: ukn

20c. Location - City or Town, State: unknown

21. Signature of Funeral Service Licensee: Larry Cuffee

22. Name and Address of Facility: Capitol Mortuary, Inc. 1425 Maryland Ave., NE Wash., DC 20002

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Coronary artery Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- Renal failure
- Sepsis
- Diabetes

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: Laeq Ahmad

29c. License number: 26021

29d. Date signed (Month, Day, Year): 11-26-99.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Laeq Ahmad 7335-B Hanover Pkwy. Greenbelt, Md. 20770

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39546

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gerald Carp
2. Date of Death Month Day Year: November 30, 1999
3. Time of Death: 4:20 AM
4a. Facility Name *(If not institution, give street and number)*: Casey House
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 108-18-6959
6. Sex: 1☐ M 2☐ F — X
7. Age *(In yrs. last birthday)*: 75 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug 20, 1924
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8613 Fox Run
10f. Zip Code: 20854
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Engineer
16b. Kind of Business/Industry: Science Application

17. Father's Name *(First, Middle, Last)*: Phillip Carp
18. Mother's Name *(First, Middle, Maiden Surname)*: Fay Smith

19a. Informant's Name/Relationship *(Type, Print)*: Lisa Carp (wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8613 Fox Run, Potomac, Maryland 20854

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)* — X
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory
Date: 12-1-99
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: ▶ Carol A Dehn
22. Name and Address of Facility: Rapp Funeral & Cremation Services, Stephen D. Lohrmann, PA
933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on aach line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Prostate Cancer — 5 Years

Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Cord Compression from bone mets — 2 months

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hydrocephalus
Urinary Tract Infection

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No — X
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Hospice — X

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Linda M Burrell
29c. License number: D35996
29d. Date signed *(Month, Day, Year)*: November 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Linda M. Burrell, M.D., 2101 Medical Park Drive, #210, Silver Spring, Maryland 20902

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 0 1 1999
32. Registrar's Signature: Steven B. Sand

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

20

DEC 0 1 1998

99-7029-031
DDG
BERNARD A. CARVER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39547

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Bernard A. Carver	NOVEMBER 23, 1999	1240 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
8003 GREENWOOD AVENUE #1	TAKOMA PARK	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
372-50-6443	1 [X] M 2 [ ] F	49 Yrs.			Oct. 26, 1950	Michigan

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Takoma Park	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8003 Greenwood Ave., #1	20912	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: African American

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Professor	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
D. A. Carver	Annie Thomas

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Munah Mayo - Friend	1736 South 7th St., Philadelphia, PA 19148

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Lee's Crematory	12/3/99	Clinton, MD

21. Signature of Funeral Service Licensee: John T. Stewart III

22. Name and Address of Facility: Stewart Funeral Home, 4001 Benning Rd., N.E. Wash., D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lobar Pneumonia	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [X] Yes 2 [ ] No	1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
[X] Yes 2 [ ] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Dennis J. Chute MD	O.C.M.E.	NOVEMBER 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 03 1999	

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

(5)

DEC 0 8 1988

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39548

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: James N. Craig
2. Date of Death Month Day Year: December 2, 1999
3. Time of Death: 11:03AM
4a. Facility Name *(If not institution, give street and number)*: Civista Medical Center
4b. City, Town, or Location of Death: La Plata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 579-01-8921
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug.3,1912
9. Birthplace *(State or Foreign Country)*: Virginia Charlottesville

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Newburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11200 Mt. Victoria Road
10f. Zip Code: 20664
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Self-employed
16b. Kind of Business/Industry: Truck&Auto Parts

17. Father's Name *(First, Middle, Last)*: John Craig
18. Mother's Name *(First, Middle, Maiden Surname)*: Ella Ballard

19a. Informant's Name/Relationship *(Type, Print)*: Catherine M. Craig/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: Same as item 10

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory — Date: 12/06/99
20c. Location - City or Town, State: Alexandria,Va.

21. Signature of Funeral Service Licensee: Geo P. Kalas
22. Name and Address of Facility: George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd, Oxon Hill, Md. 20745

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — 2 days
Due to (or as a consequence of):
b. Alzheimers Disease — 3 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Charles A. Umosella, M.D.
29c. License number: D30484
29d. Date signed *(Month, Day, Year)*: December 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles Umosella,M.D. 4333 Old Branch Ave. Marlow Heights,Md. 20748

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 03 1999
32. Registrar's Signature: Barbara B. Goodwin

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

(10)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39549

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ARNOLD LAVON CADE

2. Date of Death: Month Nov, Day 27th, Year 1999

3. Time of Death: 8:45pm

4a. Facility Name *(If not institution, give street and number)*: PRINCE GEORGE'S HOSPITAL

4b. City, Town, or Location of Death: CHEVERLY

4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 307-38-6457

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 59 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth *(Month, Day, Year)*: February 9,1940

9. Birthplace *(State or Foreign Country)*: Indiana

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Glenarden

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3038 Brightseat Road, #103

10f. Zip Code: 20706

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sanitation Engineer

16b. Kind of Business/Industry: Government

17. Father's Name *(First, Middle, Last)*: Robert Cade

18. Mother's Name *(First, Middle, Maiden Surname)*: Roxie Chillum

19a. Informant's Name/Relationship *(Type, Print)*: Ann Cade/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3040 Brightseat Road, #304, Glenarden, Maryland 20706

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Forest Hills Cemetery

Date: 12/02 1999

20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Metastatic Lung Disease — Months

Due to (or as a consequence of):

b. Esophageal Adenocarcinoma — Year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Metastatic brain disease

Seizure Disorder

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ K. Michael Figaro MD

29c. License number: D0052865

29d. Date signed *(Month, Day, Year)*: Nov 29, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): K. Michael Figaro, MD 3001 Hospital Drive, Cheverly, Maryland 20785

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 03 1999

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DEC 03 1959

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#23 PRT. II PER MD. G779 1-7-2000 J.A.

Certificate of Death

Reg. No. 99 39550

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Michael S. Capitello

2. Date of Death (Month, Day, Year): November 30, 1999

3. Time of Death: 11 AM

4a. Facility Name (If not institution, give street and number): Largo Landings Retirement Center

4b. City, Town, or Location of Death: Upper Marlboro

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 078-12-6072

6. Sex: 1☐M 2☐F XX

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 10, 1921

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Upper Marlboro

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 1077 Largo Road

10f. Zip Code: 20772

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: '42-'45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Printer

16b. Kind of Business/Industry: Government Printing Office

17. Father's Name (First, Middle, Last): Biagio Capitello

18. Mother's Name (First, Middle, Maiden Surname): Angela Impollonia

19a. Informant's Name/Relationship (Type, Print): Vincent Capitello/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1909 Laguna Road, Aldelphi, Maryland 20783

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington Nat'l Cem.

Date: Dec. 9, 1999

20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: Reginald VE

22. Name and Address of Facility: Pearson Funeral Home 472 N. Washington St., Falls Church, VA

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Coronary artery disease

Due to (or as a consequence of):

b. Hypertension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Smoking

Chronic alcoholism

23b. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year): NA

28b. Time of Injury: NA M

28c. Injury at Work? 1☐Yes 2☐No NA

28d. Describe how injury occurred: NA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): NA

28f. Location (Street and Number or Rural Route Number, City or Town, State): NA

29a. Certifier (Check only one)

1☐Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D0045881

29d. Date signed (Month, Day, Year): 12/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Carl Johnson 1221 Mercantile La Largo MD 20774

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999

32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

(10)

DEC 03 1999

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39551

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EVA CRAIG

2. Date of Death Month Day Year: November 26 1999

3. Time of Death: 7:40 a.m.

4a Facility Name *(If not institution, give street and number)*: Mariner Health Care Center

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-22-4737

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: September 10,1922

9. Birthplace *(State or Foreign Country)*: Washinton, D.C.

Usual Residence of Decedent

10a. State | 10b. County | 10c. City, Town or Location: Washington, D.C. | 10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5328 East Capitol Street, N.E.

10f. Zip Code: 20019

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 6th | College (1-4or 5+)

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Domestic

16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Edward Spears

18. Mother's Name *(First, Middle, Maiden Surneme)*: Mary Weldon

19a. Informant's Name/Relationship *(Type, Print)*: Barry Craig/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13611 United Lane, Bowie, Maryland 20720

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: Forest Hills Cemetery | Date: 11/30 1999

20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name end Address of Facility: J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting In death): a. Pneumonia

Due to (or as a consequenca of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco uas contributs to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es stated. 2☐ **Medical Examinsr:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and piece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Elliot R Goldstein

29c. License number: D03581

29d. Date signed *(Month, Day, Year)*: 11/29/1999

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): Dr. Elliot Goldstein 9410 Old Georgetown Rd. Bethesda, Md. 20814

State Registrar

31. Dete filed *(Month, Day, Year)*: NOV 30 1999

32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

NOV 3 0 1988

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39552

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Richard Kenneth Clifton
2. Dete of Deeth: Month November Dey 27 Year 1999
3. Time of Deeth: 2:55AM
4e. Fecility Neme *(If not institution, give street end number)*: Charlotte Hall Veterans Home
4b. City, Town, or Location of Daath: Charlotte Hall
4c. County of Deeth: St. Mary's

Funeral Director

5. Social Security Number: 215-36-5449
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Yeer)*: Oct. 9,1917
9. Birthpleca *(State or Foreign Country)*: MN

Usuel Residence of Decedent

10e. Stete: Maryland
10b. County: Prince George's
10c. City, Town or Location: Clinton
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 9211 Brandywine Road
10f. Zip Code: 20735
10g. Citizen of Whet Country?: U.S.A.
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1939-1955
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Rece - Americen Indien, Black, White, etc. Specify: White
15. Decedent's Edeetion *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12th; College (1-4or 5+): N/A
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Retired E-6 U.S. Navy
16b. Kind of Buainess/Industry: U.S. Government
17. Father's Name *(First, Middle, Last)*: Thomas Ross Clifton
18. Mother's Name *(First, Middle, Meiden Sumame)*: Sigrid Hessleberg
19e. Informent's Name/Relationship *(Type, Print)*: Margaret M. Clifton (Wife)
19b. Mailing Address *(Street end Number or Rural Route Numbar, City or Town, Stete, Zip Coda)*: 9211 Brandywine Road Clinton, Maryland 20735
20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, crematory or other place)*: Maryland State Veterans Cemetery — Date: Nov. 30,1999
20c. Location - City or Town, Stete: Cheltenham, Maryland
21. Signeture of Funerel Service Licensee: [signature]
22. Name end Address of Fecility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, Maryland 2

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020 27, 1999 2:55 AM NOVEMBER CP

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the moda of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one cause on aach line.

Approximate Interval Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in death):
e. CONGESTIVE HEART FAILURE — Weeks

Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE — months

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest:
Due to (or as e consequence of):
c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — Years
Due to (or as e consequence of):
d. NON-INSULIN DEPENDENT DIABETES — Years

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying ceuse given in Pert I.
CHRONIC RENAL FAILURE
ANEMIA

23b. Did tobacco uee contribute to the cause of deeth? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Wes en autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings aveilable prior to completion of ceusa of deeth? 1 [ ] Yes 2 [ ] No N/A

25. Was cese referred to medicel exeminer? 1 [ ] Yes 2 [X] No
26. Piece of Deeth *(Check only one)*: Hospitel: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28e. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, streat, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner:** On the besis of exemination end/or Investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Paul Stamis
29c. License number: D45092
29d. Date signed *(Month, Dey, Year)*: 11/29/99
30. Neme end address of person who completed ceuse of deeth (Item 23a) (Type, Print): 110 HOSPITAL ROAD SUITE 204 PRINCE FREDRICK, MD 20678

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, RICHARD K CLIFTON

(10) IVa

State Registrar

31. Dete filed *(Month, Day, Year)*: NOV 30 1999
32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

99-7092-033
B.K.S

GLORIA JEAN CANADA

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39553

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GLORIA JEAN CANADA

2. Date of Death (Month, Day, Year): NOV. 27, 1999

3. Time of Death: 0759 AM

4a. Facility Name (If not institution, give street and number): 10812 SOUTHALL DRIVE

4b. City, Town, or Location of Death: UPPER MARLBORO

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 229-74-6884

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 49 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 5/22/50

9. Birthplace (State or Foreign Country): MARTINSVILLE, VA.

Usual Residence of Decedent

10a. State: MD

10b. County: PG

10c. City, Town or Location: LARGO

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 10812 SOUTH HALL DRIVE

10f. Zip Code: 20772

10g. Citizen of What Country? USA

11. Meritat Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No Specify:

14. Race - American Indien, Black, White, etc. NEGRO Specify:

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 YEARS | College (1-4or 5+): 5 YEARS

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER

16b. Kind ot Businass/Industry: EDUCATION

17. Father's Name (First, Middle, Last): NATHANIEL GRAVLEY

18. Mother's Neme (First, Middle, Maiden Surneme): ELSIE MILNER

19a. Informant's Name/Relationship (Type, Print): JOE CANADA (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): SAME AS 10A,B,C,D,E,&F

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of Cemetery, Crematory, or Other Place) CARVER MEMORIAL GARDENS Date 12/3/99

20c. Location - City or Town, Stete MARTINSVILLE, VA.

21. Signature of Funeral Service Licensee #CC0273 ▶ Juan Smith

22. Name and Address of Facility: JOHN T. RHINES CO., INC. 3030 12TH ST NE, DC 20017

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on aach line.

Approximete Interval Between Onsat end Death

Immediete Cause (Finel disease or condition resulting in death)
a. Hypertensive cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☒ Yes 2☐ No

24b. Wera autopsy findings aveileble prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only ona): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and dua to tha causa(s) and mannar as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and placa, and dua to tha causa(s) and manner stated.

29b. Signeture and title of certifier ▶

29c. License number: O.C.M.E

29d. Data signed (Month, Day, Year): NOV. 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 01 1999

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

10

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39554

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Victor E. Carncross

2. Date of Death (Month, Day, Year): November 25, 1999

3. Time of Death: 7:47PM

4e Facility Neme (If not institution, give street end number): Doctors' Community Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 390 14 8575

6. Sex: 1☐M 2☐F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Day, Year): Dec. 30, 1921

9. Birthpleca (State or Foreign Country): Wisconsin

Usuel Residence of Decedent

10e. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Bowie

10d. Inside City Limits: ☒Yes 2☐No

10e. Street and Number: 12708 Kingsfield Lane

10f. Zip Code: 20715

10g. Citizen of Whet Country?: United States

11. Meritel Stetus: 1☐Never Merried 2☒Merried 3☐Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yeer or Detes: 40-60

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Raca - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Corpsman

16b. Kind of Business/Industry: U.S. Navy

17. Father's Neme (First, Middle, Last): Harry L. Carncross

18. Mother's Neme (First, Middle, Maiden Surneme): Ardrlla L. Smith

19e. Informent's Neme/Reletionship (Type, Print): Irma I. Carncross

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 12708 Kingsfield Lane Bowie Maryland 20715

20e. Method of Disposition: 1☒Buriel 2☐Cremetion 3☐Removel from State 4☐Donetion 5☐Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other place) Date: Dec. 3, 1999 — Arlington National Cemetery

20c. Location - City or Town, Stete: Arlington Virginia

21. Signature of Funeral Servica Licensee: ▶ James K Goovne

22. Name end Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediate Ceuse (Finel diseese or condition resulting in deeth):
a. Acute myocardial ischemic — 30 minutes

Due to (or es a consequence of):
b. Coronary artery disease — years

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest

Due to (or es e consequence of):
c. Coronary arteriosclerosis — year

Due to (or es e consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD with emphysema, Severe

Pneumothorax

Congestive heart failure

23b. Did tobacco uae contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Wes en autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred to medical exeminer? 1☐Yes 2☑No

26. Place of Deeth (Check only one): Hospitel: 1☑Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Deeth: 1☐Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner as stated. 2☐ Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred et the time, date end pleca, and due to the cause(s) end manner steted.

29b. Signeture and title of certifier: ▶ William McGynn D

29c. License number: D20633

29d. Date signed (Month, Day, Year): 11/27/99

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): 7700 Old Branch Ave. Dr05 Clinton Maryland 20735

State Registrar

31. Date filed (Month, Dey, Year): NOV 29 1999

32. Registrer's Signeture: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

CARNCROSS, Victor

CR

(10) IVa

NOV 2 0 1939

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39555

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gwendolyn CLOPTON

2. Date of Death: Month 11 Day 24 Year 99

3. Time of Death: 830PM

4a. Facility Name (If not institution, give street and number): University of MARYLAND HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 228-70-9432

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 50 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 31, 1949

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: District of Columbia

10b. County:

10c. City, Town or Location: Washington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1401 Tuckerman St., N.W. #303

10f. Zip Code: 20011

10g. Citizen of What Country?: United States

11. Meritel Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretarial

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): George Price Clopton

18. Mother's Name (First, Middle, Maiden Surname): Louise A. Mack

19a. Informent's Name/Relationship (Type, Print): Marc Orel Clopton - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6216 - 9th St., N.W. Wash., D.C. 20011

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Clopton Family Cemetery | Date: 12/2/99

20c. Location - City or Town, State: Wingina, VA

21. Signature of Funeral Service Licensee: John T. Stewart, III

22. Name and Address of Facility: Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS

Due to (or as a consequence of):
b. LYMPHOMA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: P12381

29d. Date signed (Month, Day, Year): November 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alex Chudnofsky M.D. 22 S. Greene Street Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999

32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

NOV 2 3 1938

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39556

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN HARMON CONRAD
2. Date of Death (Month, Day, Year): DECEMBER 6, 1999
3. Time of Death: 6:30 AM
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 705-10-7504
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 8, 1908
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1599 Carey Place
10f. Zip Code:
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1944-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0-12 — College (1-4or 5+): 0
16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired): city clerk
16b. Kind of Business/Industry: city government

17. Father's Name (First, Middle, Last): Samuel Hendricks
18. Mother's Name (First, Middle, Maiden Surname): Mary Esther Sinn

19a. Informent's Neme/Relationship (Type, Print): Mrs. Margaret Conrad/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1599 Carey Place, Frederick, Maryland 21701

20e. Method of Disposition: 1 ☒ Buriat 2 ☐ Cremation 3 ☐ Removat from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rest Haven Cemetery
Dete: Dec. 8, 1999
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signeture of Funeral Service Licensee: Scott Minnich
22. Name and Address of Facility: Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediate Ceuse (Finet disease or condition resulting in death)
a. Infracerebral hemorrhage — 5 days
Due to (or as a consequence of):
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last
b. Hypertension — 10 years
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: N/A

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Naturat 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end manner es steted. 2 ☐ **Medicat Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date end piece, end due to the cause(s) and manner stated.
29b. Signature and title of certifier: M Raphaelson MD
29c. License number: D26660
29d. Date signed (Month, Day, Year): 12/6/99
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Mark Raphaelson 172 Thomas Johnson Dr. #100, Frederick MD 21702

State Registrar

31. Dete filed (Month, Day, Year): DEC 13 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39557

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MABEL CHERRICO

2. Date of Death Month Day Year: December 2 1999

3. Time of Death: 11:30pm

4a. Facility Name *(If not institution, give street and number)*: Civista Medical Center

4b. City, Town, or Location of Death: LaPlata

4c. County of Death: Charles

Funeral Director

5. Social Security Number: 577-10-9997

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 13,1917

9. Birthplace *(State or Foreign Country)*: Washington,D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Charles

10c. City, Town or Location: Waldorf

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2264 Hopkins Court

10f. Zip Code: 20602

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Bookkeeper

16b. Kind of Business/Industry: Medical Supply Company

17. Father's Name *(First, Middle, Last)*: Joseph W. Henson

18. Mother's Name *(First, Middle, Maiden Surname)*: Donia Ingram

19a. Informant's Name/Relationship *(Type, Print)*: Sharon Lyster

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2210 Green Arbour Court, Waldorf, Maryland 20602

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland Veterans' Cem. | Data: 12-08-1999

20c. Location - City or Town, State: Cheltenham, Maryland

21. Signature of Funeral Service Licensee: JOHN P. KNISLEY M01164

22. Name and Address of Facility: The Huntt Funeral Home, Inc. P.O. Box 156, Waldorf, Maryland 20604

To Be Completed by Funeral Director

Mabel Cherrico

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

mew

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE RESP. FAILURE — FEW DAYS

Due to (or as a consequence of):

b. PNEUMONIA — DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: V Patel

29c. License number: D - 44436

29d. Date signed *(Month, Day, Year)*: DEC 03 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ashvinkumar J. Patel,MD — 6 Industrial Park Drive Suite B Waldorf, Maryland 20601

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 06 1999

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39558

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: STEPHEN FRANCIS CURRAN, JR.

2. Date of Death — Month: November Day: 29 Year: 1999

3. Time of Death: 10:50 AM

4a. Facility Name *(If not institution, give street and number)*: 113 Royal Oak Drive

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 077-38-7264

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 54 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Apr. 14, 1945

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 113 Royal Oak Drive

10f. Zip Code: 21015

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: Vietnam

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Hydro Geologist

16b. Kind of Business/Industry: U.S. Government

17. Father's Name *(First, Middle, Last)*: Stephen Francis Curran, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Estelle (nmn) Snyder

19a. Informant's Name/Relationship *(Type, Print)*: Kathleen L. Stewart / Fiancee

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1051 Wingate Ct., Bel Air, MD 21014

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Greenfield Cemetery

Date: 12-3-99

20c. Location - City or Town, State: Long Island, New York

21. Signature of Funding Service Licensee ▶ [signature]

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the disease (or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure). List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Rectal cancer — Due to (or as a consequence of): — 3yrs, 6months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Date of Injury *(Month, Day Year)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: [signature] DIRECTOR, MEDICAL ONCOLOGY

29c. License number: D23675

29d. Date signed *(Month, Day, Year)*: November 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROSS C. CONETTA, MD Johns Hopkins Oncology Center. Baltimore, MD 21287

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 30 1999

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39559

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mildred Elaine Campbell

2. Date of Death (Month, Day, Year): DECEMBER 4, 1999

3. Time of Death: 2:25AM

4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE, CITY

4c. County of Death:

Funeral Director

5. Social Security Number: 220-34-0176

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar 16, 1939

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 609 Biggs Avenue

10f. Zip Code: 21702

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerical Supervisor

16b. Kind of Business/Industry: Parole & Probation

17. Father's Name (First, Middle, Last): Leroy Franklin Rice

18. Mother's Name (First, Middle, Maiden Surname): Ruth Frances Michael

19a. Informant's Name/Relationship (Type, Print): Jon B. Campbell/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 609 Biggs Avenue, Frederick, Maryland 21702

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Rocky Springs Cemetery | Date: 12/8/1999

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Kathryn Roberts

22. Name and Address of Facility: Keeney & Basford P.A. Funeral Home, 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Sepsis	3 weeks
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Septic left hip	3 weeks
Due to (or as a consequence of):		
c.	Perforated duodenal ulcer	10 days
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Primary pulmonary hypertension

Adrenal insufficiency

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Medicine Housestaff

29c. License number: RES-000

29d. Date signed (Month, Day, Year): December 4, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CAMILLE PEART VIGILANCE JOHNS HOPKINS HOSPITAL, BALTIMORE, MD

State Registrar

31. Date filed (Month, Day, Year): DEC 06 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39560

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death (Month, Day, Year)	3. Time of Death
Ying-Wo	Chen	December 3, 1999	12:58 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Memorial Hospital	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
474-04-8314	1☐ M 2☒ F	71 Yrs.			Sept. 3, 1928	Taiwan

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Frederick	Frederick	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8232 Skipwith Drive	21702	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Taiwanese

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Tyau-Shin Huang	Tou Chen

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Shin-Lin Chen, Son	8232 Skipwith Drive, Frederick, Maryland 21702

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Smithsburg Crematory, Dec. 5,	1999	Smithsburg, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Richard E. Gray M00255	Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Subarachnoid hemorrhage	36hrs
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Lloyd E. Halvorson	D 22019	December 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
LLoyd E. Halvorson, M.D., 1475 Taney Avenue, Frederick, Maryland 21702

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 06 1999	▶ Donna G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39561

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joan Cannon

2. Data of Daath — Month: Nov Dey: 27 Yaar: 99

3. Tima of Daath: 8:30 pm

4a. Facility Name (If not institution, giva street and numbar): Charlestown Care Center

4b. City, Town, or Location of Daath: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Numbar: 207-26-2588

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 67 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Nov 9 1932

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residance of Decedant

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Straet and Number: 707 Maiden Choice Lane

10f. Zip Coda: 21228

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Navar Married 2☐ Married 3☐ Widowad 4☒ Divorced

12. Was Dacedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Spacify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yes 2☒ No Specify:

14. Raca - Amarican Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highast grada completad): Elamentary/Secondary (0-12): — College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired): Secretary

16b. Kind of Businass/Industry: Columbia Gas Systems

17. Fathar's Nama (First, Middla, Last): John T. Lamplugh

18. Mother's Nama (First, Middle, Maidan Surnama): Nida Knorr

19a. Informant's Name/Ralationship (Type, Print): Tracy Cannon / Daughter

19b. Mailing Addrass (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda): 12 A-2 Spa Creek Landing Annapolis, Maryland 21403

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other (Specify)

20b. Placa of Disposition (Nama of camatary, crematory or othar placa): Ft. Lincoln Crematory

Data: 11-29-99

20c. Location - City or Town, Stata: Brentwood, Maryland

21. Signature of Funaral Service Licansa: ▶ C. Brian Powell

22. Nama and Address of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester Street Annapolis, Md. 21401

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseasa, or complications that caused the daath. Do not entar tha mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on each line.

Approximata Interval Batwaan Onsat and Daath

Immediata Causa (Final diseasa or condition resulting in daath):
a. End Stage Parkinson's Disease — Years
Dua to (or as a consaquanca of):

Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Causa (Disaesa or injury thet initiated avents resulting in deeth) Last:
b. Dua to (or as a consequance of):
c. Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☑ No

25. Was casa referred to medical axaminar? 1☐ Yes 2☑ No

26. Placa of Daath (Check only ona) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Homa 5☐ Residence 6☐ Othar (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be datarminad

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, street, factory, offica building, atc. (Specify)

28f. Location (Straat and Numbar or Rural Routa Numbar, City or Town, Stata)

29a. Cartifiar (Check only one): 1☑ **Certifying Physician:** To the bast of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, deeth occurred at tha tima, data and place, and dua to tha causa(s) and mannar stated.

29b. Signatura and title of certifier: ▶ Andres Salazar MD

29c. Licansa number: D51051

29d. Data signad (Month, Day, Year): November 27, 1999

30. Name and address of person who completed causa of daath (Item 23a) (Type, Print): Andres Salazar 711 Maiden Choice Lane Catonsville, MD, 21228

State Registrar

31. Data filed (Month, Day, Year): DEC 03 1999

32. Registrar's Signatura: Geneva G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Name: Joan Cannon

Division of Vital Records, P.O. Box 68760,

12

b

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39562

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Lea Florence Cassidy	Nov. 23, 1999	11:15 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Manor Care of Kensington	Kensington	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
087-28-6764	1☐ M 2☒ F	89 Yrs.			Feb. 27, 1910	New York

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Kensington	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3000 McComas Avenue	20895	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8	-	Ward Secretary	Hospital

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph Shreiber	Frances Beirman

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lee M. Cassidy/ Son	1503 N. Colonial Court, Arlington, VA 22209

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Pinelawn Memorial Park	Nov. 27, 1999	Farmingdale, New York

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
M00689	Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Aspiration Pneumonia	2 weeks
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Dehydration	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cervical Subluxation

Dementia

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D53528	November 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daphna Henkin, M.D. 2309 Shorefield Road, Wheaton, Maryland 20902

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 30 1999	Linda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39563

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard Paul Coates, Jr.

2. Date of Death: Month November Day 20 Year 1999

3. Time of Death: 2:20 AM

4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 212-68-4951

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 43 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 3, 1956

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Brandywine

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 4805 Wilkerson Road

10f. Zip Code: 20613

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer

16b. Kind of Business/Industry: Agriculture

17. Father's Name (First, Middle, Last): Richard Paul Coates, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Rose Marie Magera

19a. Informant's Name/Relationship (Type, Print): Rose Marie Wilkinson Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4805 Wilkerson Road, Brandywine, MD 20613

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Heart Cemetery | Date: Nov. 23, 1999

20c. Location - City or Town, State: Monogahelia, PA

21. Signature of Funeral Service Licensee: Karen J. Woodall

22. Name and Address of Facility: Metropolitan Funeral Service, Inc 5517 Vine Street, Alexandria, VA 22310

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Massive Cerebral Infarcts — 10 days

Due to (or as a consequence of): b. VASCULITIS — 14 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Accelerated Hypertension

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one) — Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Date of Injury (Month, Day Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Lucio S. Villa-Real, M.D.

29c. License number: D0015513

29d. Date signed (Month, Day, Year): 11/20/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LUCIO S. VILLA-REAL, M.D. 410 ST. PATRICK'S DRIVE, SUITE 507, WALDORF, MD 20603

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39564

Amend #26:Pt-2,12/6/99, BMW,Montg.Co.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Ann Ophelia Colton Curry Cohen	Nov. 29, 1999	1:30 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Suburban Hospital	Bethesda	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-12-3249	1☐ M 2☒ F	92 Yrs.			Oct.19, 1907	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	Montgomery	Chevy Chase	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8700 Jones Mill Road	20815	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Detes:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	Collega (1-4or 5+)		
12		Administrative Assistant	U.S. Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Richard Johnson Colton	Mary Emily Hodge

19a. Informent's Neme/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Maryann C. Wilson/Daughter	10703 Kings Riding Way #202 N.Bethesda,Md. 20852

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)	Arlington Nat'l Cemetery	Dec. 3, 1999	Arlington, Va.

21. Signature of Funeral Service Licensee: John F. DeVol

22. Name end Address of Facility: DeVol Funeral Home, 2222 Wisconsin Ave., N.W. Wash. D.C. 20007

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Intestinal Obstruction

Due to (or as e consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Last

b. Rectal Carcinoma

Due to (or es e consequence of):

c. ~~Hypokalemia~~

Due to (or es e consequence of):

d. ~~Dehydration~~

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Septicemia, Dehydration, Hypokalemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Wes case referred to medicat examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signeture and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Thomas G. Zurc M.D.	D35110	NOV. 29, 1999

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print): Thomas G. Zurc, M.D., 5530 Wisconsin AVE. #1455, Chevy Chase, Md. 20815

State Registrar

31. Dete filed (Month, Dey, Year)	32. Registrer's Signeture
DEC 03 1999	Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

99-7-88-033
DDG
KENNETH S. COLLINS
Amend #20a,b,c, 12/2/99,BMW,Montg.Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39565

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kenneth Sanders Collins
2. Date of Death (Month, Day, Year): NOVEMBER 27, 1999
3. Time of Death: 0545 AM
4a. Facility Name (If not institution, give street and number): BALTIMORE WASHINGTON PARKWAY (NORTHBOUND)
4b. City, Town, or Location of Death: CHEVERLY
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 386-60-0869
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 44 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct.13,1955
9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: Md
10b. County: Prince George
10c. City, Town or Location: Greenbelt
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10a. Street and Number: 5829 Cherrywood Terrace #302
10f. Zip Code: 20770
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Communications/Security
16b. Kind of Business/Industry: Security

17. Father's Name (First, Middle, Last): Buford Collins
18. Mother's Name (First, Middle, Maiden Surname): Dorothy J. Sanders

19a. Informant's Name/Relationship (Type, Print): Dorothy J.Collins/Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2316 Atkinson Detroit,Michigan 48206

20a. Method of Disposition: 1 [X] Burial 2 [ ] ~~Cremation~~ 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ~~Meadowcrest Crematory~~ Detroit Mem Pk West
Date: ~~12/01/99~~ 12/7/99
20c. Location - City or Town, State: ~~Detroit,Michigan~~ Redford, MI

21. Signature of Funeral Service Licensee: Philip D Rinaldi
22. Name and Address of Facility: PHILIP D.RINALDI FUNERAL SERVICE 11818 New Hampshire Ave.Silver Spring,Md

Physician /Medical Examiner

23a. Part1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Injuries
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [XX] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [XX] Other (Specify) SCENE

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): 11-27-99
28b. Time of Injury: 0523 M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Driver auto - fixed object collision
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Roadway
28f. Location (Street and Number or Rural Route Number, City or Town, State): Baltimore Washington Parkway

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [XX] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): NOVEMBER 27, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39566

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothy Connor
2. Data of Death Month Day Year: December 1, 1999
3. Time of Death: 7:50 am
4a. Facility Name *(If not institution, giva street and number)*: Casey House 6001 Muncaster Mill Road
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 160-22-4035
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 70 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Dec 18, 1928
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Rasidance of Decedent

10a. Stata: Maryland
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2923 Faulkner Place
10f. Zip Code: 20895
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Nevar Marriad 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Year or Datas:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elemantary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Fathar's Nema *(First, Middla, Last)*: Joseph Michael Gottschalk
18. Mother's Nama *(First, Middle, Maiden Surname)*: Margaret Mary Neimmer

19a. Informant's Name/Ralationship *(Type, Print)*: Carole Anne Connor/ Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2923 Faulkner Place, Kensington, MD 20895

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cemetary, crematory or other place)*: Metropolitan Crematory
Data: 12/2/99
20c. Location - City or Town, Stata: Alexandria, VA

21. Signature of Funeral Service Licensee: Robert E Ramsey
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W, Silver Spring,MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complicetions that caused the death. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only one cause on aach line.

		Approximete Interval Between Onset and Death
Immedieta Causa (Final disaasa or condition rasulting in death)	a. Bowel obstruction - complication	3 Weeks
Due to (or as a consequence of):	b. Previous surgery for diverticulitis	8 years
Sequantially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disaasa or Injury that initiated avants rasulting in death) Last	c.	
Dua to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

Autosomal Dominant Cerebellar Atrophy

Arthritis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yas 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was casa rafarred to medical examinar? 1☐ Yas 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Hospice

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending invastigetion 6☐ Could not be datarmined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the tima, date and place, and dua to the cause(s) end manner as stated. 2☐ **Medicat Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner steted.

29b. Signature and title of certifier: E.P. Libre MD
29c. License number: D09470
29d. Data signed *(Month, Day, Year)*: December 1, 1999

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Eugene P. Libre, M.D. 10400 Connecticut Ave., Kensington, MD 20895

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 03 1999
32. Registrar's Signatura: Lenore G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39567

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GLEEN B. COOPER SR.

2. Data of Death Month Day Year: NOVEMBER 27, 1999

3. Time of Death: 3:50 PM

4a Facility Name (If not institution, give street and number): 1601 HENRY ROAD

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 465 28 8248

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): AUG.16,1925

9. Birthplace (State or Foraign Country): TEXAS

Usual Residence of Decedent

10a. Stata: MD.

10b. County: MONTGOMERY

10c. City, Town or Location: SILVER SPRING

10d. Inside City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Number: 1131 HORNELL DRIVE

10f. Zip Code: 20905

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Giva Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - Amarican Indian, Black, Whita, atc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired): TEACHER

16b. Kind of Businass/Industry: EDUCATION

17. Fathar's Nama (First, Middla, Last): ARCHIE C. COOPER

18. Mothar's Nama (First, Middla, Maidan Surname): NANCY BOATMAN

19a. Informant's Name/Reletionship (Type, Print): CAROLYN C. BISE, DAUGHTER

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 1601 HENRY ROAD, ROCKVILLE, MD. 20851

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removat from Stata 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Nama of cemetary, crematory or other place): PARKLAWN CEMETERY

Data: 12/2/99

20c. Location - City or Town, State: ROCKVILLE, MD.

21. Signature of Funeral Service Licensee: ▶ Muriel H. Barber

22. Name and Address of Facility: MURIEL H. BARBER FUNERAL HOME POBOX 5038, LAYTONSVILLE, MD. 20882

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on aach line.

Approximata Interval Between Onsat snd Daath

Immediata Causa (Final diseasa or condition rasulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Were sutopsy findings available prior to compiation of causa of desth? 1 [ ] Yes 2 [X] No

25. Was case referred to medicat examiner? 1 [ ] Yas 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Othar (Specify) Daughter's Home

27. Mennar of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et tha time, data and place, and dua to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Bennett Morrison MD

29c. License number: D 47682

29d. Data signad (Month, Day, Year): NOVEMBER 29,1999

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): BENNETT MORRISON, M.D. 2901 Olney/Sandy Spring Road, Olney, MARYLAND 20833

State Registrar

31. Data filed (Month, Day, Year): NOV 30 1999

32. Registrar's Signatura: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39568

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SYLVIA G. COOPER
2. Date of Death (Month, Day, Year): NOVEMBER 29,1999
3. Time of Death: 3:20 PM
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-18-3613
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 29,1922
9. Birthplace (State or Foreign Country): WASHINGTON,DC

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 14508 HOMECREST ROAD
10f. Zip Code: 20906
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates: X
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify: XX
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): ISADORE GORDON
18. Mother's Name (First, Middle, Maiden Surname): LILLIAN PEISNER

19a. Informant's Name/Relationship (Type, Print): MICHELLE STOCKHAUS (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7932 GUNSTON WOODS PL.-LORTON, VIRGINIA 22079

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): JUDEAN MEMORIAL GARDENS
Data: 12/1/99
20c. Location - City or Town, State: OLNEY, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Respiratory failure
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Renal failure
Due to (or as a consequence of):
c. Ischaemic Cardiomyopathy
Due to (or as a consequence of):
d. Epidural Abscess

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dysphagia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: [signature] MD
29c. License number: D 051114
29d. Date signed (Month, Day, Year): NOVEMBER, 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JATINDER S. SEKHON 2401 Research Blvd. Suite 102 Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year): DEC 01 1999
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39569

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Marie T. Cox

2. Dete of Deeth Month Day Yaar: November 24, 1999

3. Time of Deeth: 4:42PM

4a. Fecility Name *(If not institution, giva street and number)*: Washington Adventist Hospital

4b. City, Town, or Location of Deeth: Takoma Park

4c. County of Deeth: Montgomery

Funeral Director

5. Sociel Security Number: 577-34-7236

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: June 20, 1911

9. Birthplece *(State or Foraign Country)*: Washington, D.C.

Usuel Residence of Decedent

10a. Steta: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street end Number: 9310 Glenville Road

10f. Zip Code: 20901

10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Yeer or Datas:

13. Was Dacedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Amarican Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk

16b. Kind of Busiress/Industry: Carpenter's Union

17. Fethar's Name *(First, Middle, Last)*: Herbert Hayden

18. Mother's Name *(First, Middle, Maiden Sumame)*: Lillian Gill

19a. informent's Neme/Relationship *(Type, Print)*: Terrence John Cox, Sr. (son)

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 9321 Bandera Street Lanham, Maryland 20706

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery

Date: 11/29/99

20c. Location - City or Town, State: Silver Spring, MD

21. Signeture of Funerel Service Licensee: ▶ Tracy A. Stover

22. Neme end Address of Fecility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

b Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in deeth):
e. Hypoxia — 1 day

Due to (or es e consequence of):
b. pulmonary edema — 2-3 days

Sequentially list conditions, if eny, leeding to immediate causa. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Lest

Due to (or es a consequence of):
c. Heart Failiure — year

Due to (or es e consequence of):
d. Athero sclerotic Heart Disease — years

Part ii. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

a. severe Gastero intestinal bleedig
sepsis rheumatoid arthritis

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings eveileble prior to completion of causa of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemination and/or Investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier: ▶ Rashid Nashmi MD

29c. License number: D 39372

29d. Data signed *(Month, Day, Year)*: November 24 1999

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): RASHID NACHAT-NASHMI 3rd University Blvd West Suit 324, Silverspring md 20901

State Registrar

31. Dete filed *(Month, Day, Year)*: NOV 29 1999

32. Registrer's Signeture: ▶ Geneva G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39570

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY CALFEE CUBBY

2. Date of Death Month Day Year: NOVEMBER 24,1999

3. Time of Death: 4:25 P.M.

4a. Facility Name *(If not institution, give street and number)*: HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-20-9768

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: OCT. 8,1920

9. Birthplace *(State or Foreign Country)*: WEST VIRGINIA

Usual Residence of Decedent

10a. State: MD

10b. County: MONTGOMERY

10c. City, Town or Location: SILVER SPRING

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3612 TARKINGTON LANE

10f. Zip Code: 20906

10g. Citizen of What Country?: UNITED STATES OF AMERICA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ACCOUNTANT

16b. Kind of Business/Industry: LABOR ADMINISTRATION

17. Father's Name *(First, Middle, Last)*: WALTER B. CALFEE

18. Mother's Name *(First, Middle, Maiden Surname)*: DELOURA ROSE

19a. Informant's Name/Relationship *(Type, Print)*: WILLIAM B. CUBBY/SPOUSE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3612 TARKINGTON LANE SILVER SPRING,MARYLAND 20906

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: FT. LINCOLN CREMATORY

Date: 11/30/99

20c. Location - City or Town, State: BRENTWOOD,MARYLAND

21. Signature of Funeral Service Licensee: Thomas S. Hines

22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE. SILVER SPRING,MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. STROKE — DAYS

Due to (or as a consequence of):
CEREBROVASCULAR DISEASE — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Allen Oboler

29c. License number: D-0013456

29d. Date signed *(Month, Day, Year)*: 11/25/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALLEN OBOLER, M.D. 8830 CAMERON STREET SILVER SPRING,MARYLAND 20910

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 26 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39571

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lucy W. Douglas

2. Date of Death: Month November Day 28 Year 1999

3. Time of Death: 9:20 p.m.

4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577 40 4711

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 28, 1913

9. Birthplace (State or Foreign Country): Henderson, N.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Clinton

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 7520 Surratts Road

10f. Zip Code: 20735

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Key Punch Operator

16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Charles Wimbush

18. Mother's Name (First, Middle, Maiden Surname): Henrietta Taylor

19a. Informant's Name/Relationship (Type, Print): Elois Carter niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13708 Modrad Way #23 Silver Spring, MD 20904

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Resurrection Cemetery

Date: 12-4-99

20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: ▶ Kimberly C. Briscoe-Tonic

22. Name and Address of Facility: MARSHALL'S FUNERAL HOME OF MD 4308 Suitland Road Suitland, Maryland 20746

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE — 4 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] M

29c. License number: D-18545

29d. Date signed (Month, Day, Year): NOVEMBER 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): B. WISOTSKEY MD 12070 OCEAN SHORE CENTER WALDORF, MD 20602

State Registrar

31. Date filed (Month, Day, Year): DEC 02 1999

32. Registrar's Signature: [signature]

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(3)

DHMH 16 Rev 6/95

ORIGINAL

DEC 0 2 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39572

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES DIGGS
2. Date of Death: Month 11 Day 29 Year 1999
3. Time of Death: 0630
4e. Facility Name (If not institution, give street and number): John Hopkins Bayview
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 228-26-3827
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 19, 1927
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10e. State: Maryland
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 5505 Hopkins Bayview Circle
10f. Zip Code: 21224-2780
10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th | College (1-4or 5+):
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unknown
16b. Kind of Business/Industry: Unknown

17. Father's Name (First, Middle, Last): Duron Rose
18. Mother's Name (First, Middle, Maiden Surname): Jennie Diggs

19e. Informant's Name/Relationship (Type, Print): Adrienne Jones - Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7K Rambling Oaks Way, Baltimore, MD 21228

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Culpeper National Cem.
Date: 12/3/99
20c. Location - City or Town, State: Culpeper, VA

21. Signature of Funeral Service Licensee: John T. Stewart III
22. Name and Address of Facility: Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ISCHEMIC BOWEL — 6 HOURS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

TYPE 2 DM

MULTI-INFARCT DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael A. Ankrom MD
29c. License number: D46360
29d. Date signed (Month, Day, Year): 11/30/1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MICHAEL ANKROM 5505 HOPKINS BAYVIEW CIRCLE BALTIMORE MD 21224

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DEC 0 3 1982

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39573

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ANITA D. DASLER
2. Deta ot Deeth Month Day Yeer: NOV.29,1999
3. Time ot Deeth: 2:25 AM
4a. Facility Neme *(If not institution, give street end number)*: NATIONAL LUTHERAN HOME
4b. City, Town, or Location of Deeth: ROCKVILLE
4c. County of Deeth: MONTGOMERY CO.

Funeral Director

5. Sociel Security Number: 368-48-4731
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. lest birthdey)*: 88 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: JULY 12,1911
9. Birthplece *(State or Foreign Country)*: KANSAS

Usual Residence of Decedent

10a. Stete: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 9701- VEIRS DRIVE
10f. Zip Code: 20850
10g. Citizen ot Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — It Yes, Give Year or Detes:
13. Was Decedent ot Hispenic Origin? (Specify Yes or No- It Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: SECRETARY
16b. Kind of Business/Industry: OFFICE WORK

17. Father's Neme *(First, Middle, Last)*: ERNST BUCK
18. Mother's Neme *(First, Middle, Melden Surneme)*: ANNA PILGRIM

19a. Informent's Neme/Reletionship *(Type, Print)*: BARBARA RYDLAND-DAUGHTER
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 9913- HOLMHURST RD.,BETHESDA, MD. 20817

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Plece ot Disposition *(Neme of cemetery, cremetory or other piece)*: NORBECK MEM.GARDENS — Dete: 12/2/99
20c. Location - City or Town, Stete: OLNEY, MARYLAND

21. Signeture of Funerel Service Licensee: W. M. Hysong
22. Neme end Address ot Fecility: HYSONG CO.,INC. FUNERAL HOME 1300- N STREET, NW, WASH.,DC

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or raspiretory errest, shock, or heert teilure. List one cause on each line.

		Approximete Interval Between Onset and Deeth
Immediate Cause (Finel diseese or condition resulting in deeth) a.	Bronchopneumonia	9 days
Due to (or as a consequence of): b.	Adenocarcinoma lung	1 year
Sequentially list conditions, if any, leeding to immedieta cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Last — Due to (or es e consequence of): c.	Chronic Obstructive pulmonary disease	20 years
d.		

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause givan in Part I.: Peptic Ulcer Disease, Refluxesophagitis, Macular Degeneration

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings availeble prior to completion ot cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Plece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Menner ot Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigetion 6☐ Could not be determined
28a. Plece of Injury - At home, term, street, tectory, office building, etc. *(Specify)*
28b. Time ot Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Dete ot Injury *(Month, Dey Yeer)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end manner es steted. 2☐ **Medical Examiner**: On the besis ot exemineticn end/or invastigetion, in my opinion, deeth occurred et the time, dete end plece, and due to tha ceuse(s) end manner steted.

29b. Signeture and title of certifier: MD
29c. License number: 036618
29d. Dete signed *(Month, Dey, Yeer)*: November 29, 1999

30. Neme and eddress ot person who completed cause of death (Item 23e) (Type, Print): DR. C. SCHEMM- 9701- VEIRS DRIVE, ROCKVILLE,MD. 20850

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: DEC 01 1999
32. Registrer's Signeture: [illegible]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(12)

DHMH 16 Rev 6/95

DEC 0 7 1988

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39574

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Edward Dyer
2. Date of Death (Month, Day, Year): Nov. 28, 1999
3. Time of Death: 6:45 p.m.
4a. Facility Name (If not institution, give street and number): 2234 Hindle Lane
4b. City, Town, or Location of Death: Bowie
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 578-12-4817
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 31, 1921
9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: Md.
10b. County: Prince Georges
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 2234 Hindle Lane
10f. Zip Code: 20716
10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 1942-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Correctional Officer
16b. Kind of Business/Industry: Corrections

17. Father's Name (First, Middle, Last): George Warren Dyer
18. Mother's Name (First, Middle, Maiden Surname): Anna Mae Burroughs

19a. Informant's Name/Relationship (Type, Print): Betty Jane Dyer/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2234 Hindle Lane Bowie, Maryland 20716

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Resurrection Cemetery | Date: 12-02-99
20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: Shannon W. Beall / Shannon W. Beall M00798
22. Name and Address of Facility: Beall Funeral Home, 6512 N.W. Crain Highway Bowie, Md. 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Ventricular arrhythmia — minutes

Due to (or as a consequence of):
b. Ischemic cardiomyopathy — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Coronary artery disease — Years

Due to (or as a consequence of):
d. Diabetes mellitus — Years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, chronic atrial fibrillation, congestive heart disease, peripheral vascular disease, chronic renal insufficiency, cerebrovascular accident

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residance 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Tara T. Muscovich M.D.
29c. License number: D46992
29d. Date signed (Month, Day, Year): 11/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Tara T. Muscovich MD 1438 Defense Hwy. Gambrills, MD 21054

State Registrar

31. Date filed (Month, Day, Year): DEC 01 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DEC 01 1995

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39575

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH DWYER
2. Date of Death (Month, Day, Year): November 23, 1999
3. Time of Death: 15:40
4a. Facility Name (If not institution, give street and number): THE Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore, City
4c. County of Death:

Funeral Director

5. Social Security Number: 579-56-1338
6. Sex: 1☐M 2☐F XX
7. Age (In yrs. last birthday): 56 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 29, 1943
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☐Yes 2☒No X
10e. Street and Number: 806 4th Street
10f. Zip Code: 20707
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Navar Married 2☒Married XX 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No X If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No XX Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 11; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Fork Life Operator
16b. Kind of Business/Industry: Giant Foods
17. Father's Name (First, Middle, Last): Joseph C. Dwyer
18. Mother's Name (First, Middle, Maiden Surname): Zepha I. Crane
19a. Informant's Name/Reletionship (Type, Print): Norma Jeanne Dwyer/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1624 Chesapeake Dr. Edgewater, MD 20737
20a. Method of Disposition: XX Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery
Date: Nov. 29, 1999
20c. Location - City or Town, State: Brentwood, MD
21. Signature of Funeral Service License: Dyan F Neubauer
22. Name and Address of Facility: Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediete Cause (Final diseese or condition resulting in death)	e. Sepsis due to Klebsiella pneumoniae	7 days
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	b. End Stage Liver Disease	1 year
Due to (or as a consequence of):		
	c. Alcoholism	20 years
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: scrotal Cellulitis

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown X

24a. Wes an eutopsy performed? 1☐Yes 2☒No X

24b. Were eutopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No X

26. Place of Death (Check only one): Hospital: 1☒Inpatient X 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Netural X 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending invastigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. X
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Linda J Wolfenden MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): November 23, 1999

30. Name end address ot person who completed cause of death (Item 23a) (Type, Print): Linda Wolfenden, MD. Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, MD 21287

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999
32. Registrar's Signature: Barbara B. Lewis

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylend Department of Heelth end Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requiras thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39576

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CECELIA ELIZABETH DORSEY
2. Date of Death: Month 11 Day 25 Year 99
3. Time of Death: 3:45 PM
4a. Facility Name (If not institution, give street and number): 10200 Water Well Way
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-52-0432
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 11, 1939
9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 10200 Water Well Way
10f. Zip Code: 20708
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Budget Analyst
16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): David Robertson
18. Mother's Name (First, Middle, Maiden Surname): Helen Prince

19a. Informant's Name/Reletionship (Type, Print): Jeffrey Dorsey/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10200 Water Well Way, Laurel, Maryland 20708

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lincoln Memorial Cemetery
Date: 12/01/1999
20c. Location - City or Town, State: Suitland, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: J.B. JENKINS FUNERAL HOME, 7474 Landover Road, Landover, Maryland 20785

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Rectal Cancer — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, death occurred et the time, dete end piece, end due to the ceuse(s) and manner stated.
29b. Signature and title of certifier: Clara Chan MD
29c. License number: D41828
29d. Date signed (Month, Day, Year): November 26, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CLARA CHAN MD 9801 Georgia Ave #337, Silver Spring, MD 20902

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NOV 3 0 1995

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39577

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carl Washington Dudley

2. Date of Death (Month, Day, Year): November 23, 1999

3. Time of Death: 10:17 am

4a. Facility Name (If not institution, give street and number): 6618 Auburn Avenue

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 224-24-9216

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 9, 1915

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Lanham

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6618 Auburn Avenue

10f. Zip Code: 20706

10g. Citizen of Whel Country?: U.S.A.

11. Meritel Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrician

16b. Kind of Business/Industry: Self-Employed

17. Father's Neme (First, Middle, Last): Jacob Mohler Dudley

18. Mother's Name (First, Middle, Maiden Sumeme): Lillie Ladelle Miller

19a. Informent's Neme/Reletionship (Type, Print): Darla D. Merillat (Daughter)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 11717 Rivershore Drive, Dunkirk, Maryland 20754

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Cedar Hill Cemetery | Dete: 11/27/99

20c. Location - City or Town, Stete: Suitland, Maryland

21. Signeture of Funeral Service Licensee: Claudette J. Gasch

22. Neme end Address of Fecility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. Cancer of Throat

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior lo compleiion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accidenl 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es steted. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) and manner stated.

29b. Signeture and title of certifier:

29c. License number: D33954

29d. Date signed (Month, Day, Year): November 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mario F. Golle, Jr., M.D. 3001 Hospital Drive, Cheverly, Maryland 20785

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

15

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999

32. Registrar's Signature: Barbara B. Goode

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NOV 2 9 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39578

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RALPH VIRGIL DENT

2. Date of Death Month Day Year: NOVEMBER 21, 1999

3. Time of Death: 8:30 p.m.

4a. Facility Name (If not institution, give street and number): 199 Rollins Avenue Apt. 820

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery Co.

Funeral Director

5. Social Security Number: 228-12-3372

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 5,1922

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: [X] Yes 2 [ ] No

10e. Street and Number: 199 Rollins Avenue Apt. 820

10f. Zip Code: 20852

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mail Carrier

16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Roy S. Dent

18. Mother's Name (First, Middle, Maiden Surname): Virgil T. Stewart

19a. Informant's Name/Relationship (Type, Print): Billye Jean Dent-Armstrong/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3823 N.H. Ave., NW Wash., D.C. 20011

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Lincoln Memorial Cemetery

Date: 11/27/99

20c. Location - City or Town, State: Suitland,Maryland

21. Signature of Funeral Service Licensee: W. J. Jeffries

22. Name and Address of Facility: Frazier's Funeral Home, Inc. 389 R.I. Ave., N.W. Washington,D.C. 20001

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one) Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible]

29c. License number: MD 20459

29d. Date signed (Month, Day, Year): NOVEMBER 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. ANTHONY ARCENAS, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999

32. Registrar's Signature: [illegible]

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene 99 39579

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Catherine DiBenedetto
2. Data of Death: Month December Day 4, Year 1999
3. Tima of Deeth: 10:15 a. m.
4a. Facility Nama (If not institution, giva street and number): Avalon Manor Nursing Home
4b. City, Town, or Location of Daath: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Numbar: 144-20-7507
6. Sax: 1☐ M 2☒ F
7. Aga (In yrs. last birthday): 84 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Dec. 22, 1914
9. Birthplaca (Stata or Foreign Country): New York

Usual Residance of Decedant

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 103 N. Cleveland Avenue
10f. Zip Coda: 21740
10g. Citizan of Whet Country?: USA

11. Marital Status: 1☐ Navar Married 2☐ Marriad 3☐ Widowed 4☒ Divorced
12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yas 2☐ No If Yes, Give Year or Datas:
13. Was Dacedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:
14. Race - Amarican Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elamantary/Secondary (0-12): 10 | Collaga (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired): Sewing
16b. Kind of Business/Industry: Clothing Manufacturing

17. Fathar's Name (First, Middle, Last): Nicolo DiBenedetto
18. Mothar's Nama (First, Middle, Maidan Surnama): Angela Palumbo

19a. Informant's Name/Ralationship (Type, Print): Mary A. Scheerer Niece
19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 19238 Olde Waterford Road Hagerstown, Maryland 21742

20a. Mathod of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Ramoval from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or othar place): Rose Hill Cemetery
Deta: 12/7/99
20c. Location - City or Town, Stata: Hagerstown, maryland

21. Signature of Funeral Service Licensee: Gerald N. Minnich
22. Nama and Address of Facility: Gerald N. Minnich Funeral Home, 305 N. Potomac Street Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory errast, shock, or haart failura. List only ona ceuse on aach line.

		Approximata Intervel Batween Onsat and Deeth
Immadiata Causa (Finel diseasa or condition rasulting in daath) a.	Pneumonia	3 weeks
Dua to (or as a consaquence of):	Aspiration	unknown
Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Ceusa (Disaasa or injury that initiated avants rasulting in deeth) Last b.	
Dua to (or as a consequence of):	Senility	
c.	
Dua to (or as a consaquanca of):	
d.	

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa givan in Part I.: Hypothyroidism, Congestive Heart Failure

23b. **Did tobacco use contribute to the cause of deeth?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performad? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to complation of cause of death? 1☐ Yas 2☐ No

25. Wes casa raferred to medical examinar? 1☐ Yas 2☒ No

26. Plece of Daath (Check only ona)
Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA
Other: 4☑ Nursing Homa 5☐ Rasidence 6☐ Othar (Specify)

27. Manner of Deeth: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Yaar)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)
28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Cartifiar (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, daath occurred at the time, dete end placa, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, daath occurred at the time, dete end piece, and due to the cause(s) and mennar statad.

29b. Signatura and titla of certifier:
29c. License number: D44996
29d. Date signed (Month, Day, Yaar): Dec 6, 1999

30. Nama and address of parson who completed causa of death (Item 23e) (Type, Print): Zafar Malik 20311 Lappans Rd Boonsboro MD 21713

State Registrar

31. Dete filed (Month, Dey, Year): DEC 06 1999
32. Registrar's Signature: Denise G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39580

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): THOMAS CHARLES DEMARR
2. Date of Death (Month, Day, Year): DECEMBER 02, 1999
3. Time of Death: 1520
4a. Facility Name (If not institution, give street and number): 3521 ACCOKEEK ROAD
4b. City, Town, or Location of Death: WALDORF
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 579-38-3674
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DECEMBER 12, 1929
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: PRINCE GEORGE'S
10c. City, Town or Location: WALDORF
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3521 ACCOKEEK ROAD
10f. Zip Code: 20601
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: USA 1946-1949
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): COMMUNICATIONS SPECIALIST
16b. Kind of Business/Industry: U. S. GOVERNMENT

17. Father's Name (First, Middle, Last): THOMAS PERCEY DEMARR
18. Mother's Name (First, Middle, Maiden Surname): LETTIE VIVIAN KELLER

19a. Informant's Name/Relationship (Type, Print): MARYANN B. DEMARR
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3521 ACCOKEEK ROAD, WALDORF, MARYLAND 20601

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): TRINITY MEMORIAL GARDENS
Date: 12/06/1999
20c. Location - City or Town, State: WALDORF, MARYLAND

21. Signature of Funeral Service Licensee: JOHN P. KNISLEY M01164
22. Name and Address of Facility: THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX 156, WALDORF, MARYLAND 20604-0156

JPK

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D33954
29d. Date signed (Month, Day, Year): DECEMBER 03, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARIO F. GOLIA JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

State Registrar

31. Date filed (Month, Day, Year): DEC 06 1999
32. Registrar's Signature: Dennis G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39581

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Marie N. Davies
2. Date of Death (Month, Day, Year): December 1, 1999
3. Time of Death: 4:30 a.m.
4a. Facility Name *(If not institution, give street and number)*: Mariner Health Care
4b. City, Town, or Location of Death: Kensington
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-40-1614
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Yeer)*: Dec 6, 1914
9. Birthplace *(Stete or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 302 Sunny Brook Terrace, Apt. #717
10f. Zip Code: 20877
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 1
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary
16b. Kind of Business/Industry: Federal Government

17. Father's Name *(First, Middle, Last)*: John Street
18. Mother's Name *(First, Middle, Meiden Sumame)*: Anna Theresa Counihan

19a. Informant's Name/Relationship *(Type, Print)*: Timothy R. Davies, Son
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 302 Sunny Brook Terrace, #717 Gaithersburg, MD 20877

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Arlington National Cemetery | Date: Dec 4, 1999
20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: Timothy R. Davies
22. Name and Address of Facility: DeVol Funeral Home, 10 E. Deer Park Dr., Gaithersburg, MD 20877

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Vocal Cord Carcinoma

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequenca of):
c.
Due to (or as a consequenca of):
d.

Part II. **Othar significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia, Aspiration Pneumonia

23b. Did tobacco use contribute to the causa of death? 1☒ **Yes** 2☐ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Yeer)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piaca of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyalcian**: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated. 2☐ **Medicat Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Lynne Diggs MD
29c. License number: D84472
29d. Date signed *(Month, Dey, Yeer)*: 12/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lynne Diggs, M.D., 1500 Forest Glen Road, Silver Spring, MD 20910

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Yeer)*: DEC 03 1999
32. Registrar's Signature: Penny B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39582

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LORIMER ARTHUR DAVIDSON

2. Date of Death (Month, Day, Year): NOV. 27, 1999

3. Time of Death: 4:30 AM

4a. Facility Name (If not institution, give street and number): SUBURBAN HOSPITAL

4b. City, Town, or Location of Death: BETHESDA

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 212-28-6179

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 97 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11/7/1902

9. Birthplace (State or Foreign Country): CANADA

Usual Residence of Decedent

10a. State: MD.

10b. County: MONTGOMERY

10c. City, Town or Location: ROCKVILLE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 10401 GROSVENOR PLACE # 1702

10f. Zip Code: 20852

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CHIEF EXECUTIVE OFFICER

16b. Kind of Business/Industry: GEICO INSURANCE

17. Father's Name (First, Middle, Last): THOMAS FERGUSON DAVIDSON, II

18. Mother's Name (First, Middle, Maiden Surname): GERTRUDE SHORT

19a. Informant's Name/Relationship (Type, Print): TOM DAVIDSON- SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4755 BANBURY LANE OGDEN, UTAH 84403

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): ROCK CREEK CEMETERY | Data: 12/3/99

20c. Location - City or Town, State: WASHINGTON, DC.

21. Signature of Funeral Service Licensee: Thomas E. Combaker

22. Name and Address of Facility: Joseph Gawler's Sons 5130 Wisc. Ave. Nw. Wash. DC. 20016

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia - bilateral — 1 week

Due to (or as a consequence of):

b. Metastatic cancer — 3+ mo

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Probable Lung CA — ? yr

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Spinal Stenosis, Pathological fx L ARM

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner es stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John S. Saia MD

29c. License number: D10493

29d. Date signed (Month, Day, Year): November 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John S. SAIA, 809 Viers Mill Rd Rockville, MD 20851

State Registrar

31. Date filed (Month, Day, Year): DEC 01 1999

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DAVIDSON, LORIMER 11/27/99 4:40 AM

30

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39583

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANCES B. DAWSON

2. Date of Death: Month NOV. Day 30, Year 1999

3. Time of Death: 6:50 PM

4a. Facility Name (If not institution, give street and number): MANOR CARE HEALTH SERVICES

4b. City, Town, or Location of Death: LARGO

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 218-24-3335

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MARCH 22,1913

9. Birthplace (State or Foreign Country): PA.

Usual Residence of Decedent

10a. State: MD.

10b. County: PRINCE GEORGES

10c. City, Town or Location: BLADENSBURG

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 5999 EMERSON ST. #425

10f. Zip Code: 20710

10g. Citizen of What Country? U.S.A.

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 9 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: HOME

17. Father's Neme (First, Middle, Last): STEPHEN MAHOVLICH

18. Mother's Name (First, Middle, Maiden Surneme): ANNA PULES

19e. Informant's Neme/Relationship (Type, Print): GERALDINE TODD/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 13010 ELKRIDGE ST., BELTSVILLE, MD. 20705

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): CHAMBERS CREMATORY

Dete: 12/2/99

20c. Location - City or Town, Stete: RIVERDALE, MD.

21. Signetura of Funerel Service Licensee: W.N. Chambers

22. Name and Address of Fecility: M00091 CHAMBERS FUNERAL HOMES,P.A., RIVERDALE,MD.20737

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onset and Deeth

Immediate Cause (Final diseese or condition resulting in deeth)

a. Hypertensive Cardiovascular

Due to (or as e consequence of): Disease.

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Last

b.

Due to (or as a consequence of):

c.

Due to (or es a consequence of):

d.

Part Ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert f.

Multiinfarct Dementia, Atrial fibrillation, Cirrhosis of liver, Pancytopenia. H/o Breast carcinoma.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner stated.

29b. Signature end title of certifier: N Shah M.D

29c. License number: D 48213

29d. Dete signed (Month, Day, Year): 12-1-99.

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): N. ASHAI 4000 Mitchellville Rd #220 Bowie MD 20716

State Registrar

31. Dete filed (Month, Day, Year): DEC 02 1999

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39584

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARION DICESARE
2. Date of Death Month / Day / Year: NOVEMBER 29 1999
3. Time of Death: 1720
4e. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 018-05-1797
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 12, 1914
9. Birthplace *(State or Foreign Country)*: Italy

Usual Residence of Decedent

10a. State: Massachusetts
10b. County: Barnstable
10c. City, Town or Location: Falmouth
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13 Barbara Lane
10f. Zip Code: 02556
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Seamstress
16b. Kind of Business/Industry: Garment

17. Father's Name *(First, Middle, Last)*: Luigi Vacca
18. Mother's Name *(First, Middle, Maiden Surname)*: Nicolina Pollilla

19a. Informant's Name/Relationship *(Type, Print)*: Felica D. Garry - Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 61 Pebble Lane, POB 734, N. Falmouth, MA 02556

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Joseph's Cemetery
Date: 12/4/99
20c. Location - City or Town, State: Falmouth, MA

21. Signature of Funeral Service Licensee: Karen J. Woodall
22. Name and Address of Facility: Metropolitan Funeral Service, 5517 Vine Street, Alexandria, VA 22310-1025

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. CARDIOGENIC SHOCK — 10 DAY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. ACUTE MYOCARDIAL INFARCTION — 2 DAYS

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Virendra Saxena CRITICAL CARE CONSULTANT
29c. License number: D30112
29d. Date signed *(Month, Day, Year)*: NOVEMBER 30 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VIRENDRA K. SAXENA MD, 7100 DEER CROSSING COURT, BETHESDA MD 20817

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 03 1999
32. Registrar's Signature: [illegible]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39585

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Sallie T. Epps

2. Date of Death (Month, Day, Year): OCTOBER 06, 1999

3. Time of Death: 11:40 A.M.

4a. Facility Name *(If not institution, give street and number)*: MALCOLM GROW MEDICAL CENTER

4b. City, Town, or Location of Death: CAMP SPRINGS

4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 578-88-0247

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)* Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth *(Month, Day, Year)*: March 6,1961

9. Birthplace *(State or Foreign Country)*: Wash., D.C.

Usual Residence of Decedent

10a. State: D.C.

10b. County:

10c. City, Town or Location: Washington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 411 Oakwood Street, S.E.

10f. Zip Code: 20032

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk

16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: John Epps

18. Mother's Name *(First, Middle, Maiden Surname)*: Ada Bullock

19a. Informant's Name/Relationship *(Type, Print)*: John Epps/father

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 411 Oakwood Street, S.E. Washington, D.C. 20032

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lincoln Mem. Cemetery

Date: 10/15/99

20c. Location - City or Town, State: Suitland, MD.

21. Signature of Funeral Service Licensee: Annie Edwards

22. Name and Address of Facility: Hodges and Edwards 3910 Silver Hill RD.Suitland,Md. 20746

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PULMONARY EMBOLI

Due to (or as a consequence of):

b. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

c. MYOCARDIAL FIBROSIS

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: 0101032463 VA

29d. Date signed *(Month, Day, Year)*: NOVEMBER 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHANG Y. LIANG, COL, USAF, MC

89 MDG/1050 W PERIMETER RD ANDREWS AIR FORCE BASE, MD 20762-6600

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 02 1999

32. Registrar's Signature:

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39586

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH EYLER

2. Data of Death: Month 12 Day 04 Year 99

3. Time of Death: 1324

4a Facility Name (If not institution, give street and number): Univ. of Maryland 22 South Green St.

4b. City, Town, or Location of Death: Balt. md

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-48-6393

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 49 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): 01/21/50

9. Birthplace (State or Foraign Country): Pennsylvania

Usual Rasidanca of Decedant

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Thurmont

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 141 Emmitsburg Road

10f. Zip Code: 21788

10g. Citizen of What Country?: United States

11. Maritel Stetus: 1 ☐ Nevar Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Dacedent Evar in U.S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 ☐ Yas 2 ☒ No Specify:

14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedant's Education (Specify only highast grada completed): Elamantary/Secondary (0-12): 12 Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired): Stables Owner/Operator

16b. Kind of BusInass/Industry: Horse

17. Fathar's Nama (First, Middla, Last): Joseph Harry Eyler

18. Mother's Nama (First, Middle, Maiden Sumama): Ruth Galt

19a. Informant's Name/Ralationship (Type, Print): Josephine Eyler / Wife

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 141 Emmitsburg Road, Thurmont, Maryland 21788

20a. Mathod of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify)

20b. Place of Disposition (Nama of cematary, cramatory or other place): Blue Ridge Cemetery

Data: Dec 8 1999

20c. Location - City or Town, Stata: Thurmont, Maryland

21. Signatura of Funaral Sarvice Licensee: [signature]

22. Nama and Address of Facility: Stauffer Funeral Home 104 E. Main Street, Thurmont, Maryland 21788

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complications that caused tha daath. Do not entar tha moda of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Between Onset and Death

Immediata Causa (Final disaasa or condition rasulting in daath)

a. Septic Shock

Dua to (or as a consequance of):

b. Pneumonia

Sequentially list conditions, if any, laading to immediata causa. Entar Undarlying Cause (Disease or injury that initiated events rasulting in daath) Last

Dua to (or as a consequence of):

c. Bilateral Extremity Gangrene

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 ☑ No

24b. Wara autopsy findings available prior to completion of causa of death? 1 ☐ Yas 2 ☐ No

25. Was casa rafarrad to medical examinar? 1 ☐ Yas 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Othar (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Panding invastigation 6 ☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To tha best of my knowledga, daath occurred at the tima, data and place, and dua to tha cause(s) and mannar as stated. 2 ☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar stated.

29b. Signatura and title of certifier: Paul G. Clark

29c. License number: P 11958

29d. Data signed (Month, Day, Year): 12/04/99

30. Name and addrass of person who completed causa of daath (Item 23a) (Type, Print): Paul G. Clark 22. South Green St. Baltimore md

State Registrar

31. Data filed (Month, Day, Year): DEC 06 1999

32. Registrar's Signatura: Brenda B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39587

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LEROY ESTEP

2. Date of Daeth (Month, Day, Year): NOV. 28, 1999

3. Time of Death: 7:34 PM

4a. Facility Name *(If not institution, give street and number)*: Montgomery General Hospital

4b. City, Town, or Location of Death: Olney

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-09-8272

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan.20,1908

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Rasidance of Decedant

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 3409 Norbeck Road

10f. Zip Code: 20906

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yas, Give Year or Dates: 43-45

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade compiatad)*: Elementary/Secondary (0-12): 7th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: Clerk

16b. Kind of Businass/Industry: Homewood Hardware Store

17. Father's Name *(First, Middle, Last)*: Richard H. Estep

18. Mother's Name *(First, Middle, Maiden Surname)*: Carrie Wise

19a. Informant's Name/Relationship *(Type, Print)*: Mildred M. Snowden (Sister)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 15811 Radwick Ln, Silver Spring, MD 20906

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cem.

Date: 12/3/99

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: George K. Snowden

22. Name end Address of Facility: SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximata Interval Between Onset and Death

Immediate Cause (Final disease or condition rasulting in daath)

a. VENTRICULAR FIBRILLATION — minutes

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE — Years

Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disaasa or injury that Initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as e consequance of):

d.

Part Ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uae contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☑No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Daath *(Chack only one)*: Hospital: 1☐Inpatiant 2☑ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☑Naturel 2☐Accident 3☐Suicide 4☐Homicida 5☐Pending investigation 6☐Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Dascribe how injury occurred

28e. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑**Certifying Physician:** To tha best of my knowledge, death occurred at tha tima, data and place, and dua to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: MD

29c. License number: D38457

29d. Date signed *(Month, Day, Year)*: NOVEMBER 30, 1999

30. Name end address of person who completad cause of death (Item 23a) (Type, Print): N. GOYAL MD 2501 INTERNATIONAL DR, SILVER SPRING, MD 20906

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 01 1999

32. Registrar's Signatura: Donna G. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39588

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles William Fetz
2. Date of Death (Month, Day, Year): November 29, 1999
3. Time of Death: 7:31 AM
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 282-44-0382
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 17, 1944
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2012 Malvern Way
10f. Zip Code: 21702
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Vietnam
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): C.P.A. / Accountant
16b. Kind of Business/Industry: Electric Corporation

17. Father's Name (First, Middle, Last): Charles Fetz, Jr.
18. Mother's Name (First, Middle, Maiden Surname): Alma M. Adams

19a. Informant's Neme/Reletionship (Type, Print): Erika Anne Fetz (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18003 Cottage Garden Drive, #101, Germantown, MD 20874

20e. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: 12-2-99
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funaral Sarvice Licensee: Carol a Dehn
22. Name and Address of Facility: Rapp Funeral & Cremation Services, Stephen D. Lohrmann, PA 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

23a. Part1. Enter tha disaase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only one cause on each line.

Approximata Intervel Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in deeth)
a. Atherosclerotic cardiovascular disease — years
Due to (or as a consequence of):
b. Hypertension — years
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest
Due to (or as a consequence of):
c. Hyperlipidemia — years
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Deeth (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Panding Investigetion 6 [ ] Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es steted. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifiar: Patricia L. Tomsko, MD
29c. License number: D51916
29d. Date signed (Month, Day, Year): November 29, 1999

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Patricia L. Tomsko, MD 11140 Rockville Pike, PMB 348, Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year): DEC 01 1999
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DEC 01 1998

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39589

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM A. FLETCHER, JR.

2. Date of Death (Month, Day, Year): November 26, 1999

3. Time of Death: 10:58 P.M.

4a. Facility Name (If not institution, give street and number): Larkin Chase Nursing Home

4b. City, Town, or Location of Death: Bowie

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-12-4280

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): April 29, 1920

9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedant

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Bowie

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 10003 Dodson Court

10f. Zip Code: 20721

10g. Citizen of What Country?: U.S.A.

11. Marital Stetus: 1 [ ] Never Merried 2 [ ] Merried 3 [X] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yas, Giva Year or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedant's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 8th Grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mail Room Supervisor (Retired)

16b. Kind of Business/Industry: American Legion

17. Father's Name (First, Middle, Last): William A. Fletcher, Sr.

18. Mother's Name (First, Middle, Meiden Surname): Rose Spriggs

19a. Informant's Name/Reletionship (Type, Print): Paul E. Fletcher (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 10003 Dodson Court Bowie, Maryland 20721

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Nama of cemetery, cremetory or other place): Resurrection Cemetery

Date: 12-1-99

20c. Location - City or Town, Stata: Clinton, Maryland

21. Signeture of Funerel Service Licensee: Alfred J. Vallier

22. Name and Address of Facility: Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or haart failura. List only one cause on aech line.

Approximate Intarval Between Onset and Death

Immediata Causa (Finel diseesa or condition resulting in deeth)

e. Coronary Atheroscerosis — Years

Due to (or as a consequence of):

b. Hypertensive Cardiovascular Disease — Years

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet intieted avents resulting in death) Last

Due to (or es e consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other signficant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Alzheimers Disease

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case raferred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one)

Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury el Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner steted.

29b. Signature end title of certifier: Rakesh Arora, MD

29c. License number: D 20108

29d. Date signed (Month, Day, Year): November 29, 1999

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): Rakesh Arrora, MD. 14300 Gallant Fox Lane, Suite 222 Bowie, Maryland 20715

State Registrar

31. Deta filed (Month, Day, Year): DEC 03 1999

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DEC 0 3 1986

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39590

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GWENDOLYN MARIE FOWLER
2. Date of Death (Month, Day, Year): 12 01 99
3. Time of Death: 3:15 pm
4a. Facility Name (If not institution, give street and number): 7601 OXMAN ROAD
4b. City, Town, or Location of Death: LANDOVER
4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 578-70-0266
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 48 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 30,1951
9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Landover
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7601 Oxman Road
10f. Zip Code: 20785
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 3yrs.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Business Administrator
16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Walter D. Brooks, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Marie Hooker

19a. Informent's Name/Relationship (Type, Print): Chantice M. Cotten/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8162 Mandan Street, Greenbelt, Maryland 20770

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: 12/04 1999
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	HEPATIC FAILURE	4 WEEKS
Due to (or as a consequence of): b.	CIRRHOSIS OF THE LIVER	10 YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	HEPATOMA	WEEK
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: MD4095
29d. Date signed (Month, Day, Year): 12/02/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David A. Morowitz, M.D. 106 Irving Street, N.W., Washington, D.C. 20010

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DEC 0 3 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39591

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Geneva Stubbs Fields

2. Date of Death Month / Day / Year: November 28 1999

3. Time of Death: 1:30PM

4a. Facility Name *(If not institution, give street and number)*: Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-28-7065

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 4, 1924

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 9014 Rhode Island Ave., #514

10f. Zip Code: 20740

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* African American

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Dietary Assistant

16b. Kind of Business/Industry: Government

17. Father's Name *(First, Middle, Last)*: Harry Edward Stubbs

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Ellen Snowden

19a. Informant's Name/Relationship *(Type, Print)*: Tami V. Brown - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 40 Ark Road, Lothian, MD 20711

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Maryland Veterans Cem.

Date: 12/6/99

20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: John T. Stewart III

22. Name and Address of Facility: Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Gastric Cancer	2 Months
Due to (or as a consequence of):	b. Aspiration Pneumonia	3 Weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Sepsis	3 Weeks
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kumar Sudhakar

29c. License number: D 19971

29d. Date signed *(Month, Day, Year)*: November 29, 1999

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Kempanna Sudhakar 7610 Carroll Ave., Takoma Park, MD

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 30 1999

32. Registrar's Signature: Barbara A. Hanks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NOV 3 0 1939

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39592

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Shat Hing Fong
2. Date of Death (Month, Day, Year): November 20, 1999
3. Time of Death: 1:53AM
4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital Center
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-44-7628
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 8,1935
9. Birthplace (State or Foreign Country): New York, N.Y.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Clinton
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7909 Pinewood Drive
10f. Zip Code: 20735
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Oriental

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrician
16b. Kind of Business/Industry: I B E W Local #26

17. Father's Name (First, Middle, Last): Sing Ho Fong Lee
18. Mother's Name (First, Middle, Maiden Surname): Jew Ngook Lan

19a. Informant's Name/Relationship (Type, Print): Jeffrey Philip Fong (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4512 Poppe Place Camp Springs, Maryland 20748

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): George Washington Cemetery | Date: Nov. 29, 1999
20c. Location - City or Town, State: Adelphi, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton,MD20735

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary Artery Disease
Due to (or as a consequence of):
b. Ischemic Cardiomyopathy
Due to (or as a consequence of):
c. Hypertensive Heart Disease
Due to (or as a consequence of):
d. Cardiac Arrhythmia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Seizure Disorder
Cerebrovascular Accident

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? N/A 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Danilo G. Lee, M.D.
29c. License number: D 15789
29d. Date signed (Month, Day, Year): 11-23-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Danilo G. Lee M.D. 7700 Old Branch Avenue #D-203 Clinton, Maryland 20735

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

CR

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NOV 30 1988

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39593

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bernardine S. Finstad

2. Date of Death (Month, Day, Year): November 26, 1999

3. Time of Death: 1:30PM

4a. Facility Name (If not institution, give street and number): Sacred Heart Home

4b. City, Town, or Location of Death: Hyattsville

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 475-30-1149

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 15, 1912

9. Birthplace (State or Foreign Country): Minnesota

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☐ Yes 2☒ No XX

10e. Street and Number: 5805 Queens Chapel Road

10f. Zip Code: 20782

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Statistical Assistant

16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Adam Schnider

18. Mother's Name (First, Middle, Maiden Surname): Mary Hamm

19a. Informant's Name/Relationship (Type, Print): Cecilia Finstad/Granddaughter-in-law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 743 Harwood Road Harwood, Md. 20776

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mount Olivet Cemetery | Date: 11/29/99

20c. Location - City or Town, State: Washington, DC

21. Signature of Funeral Service Licensee: G. P. Kalas

22. Name and Address of Facility: George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon hill, Md. 20745

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction — immediate

Due to (or as a consequence of):
b. Advanced Atherosclerotic Heart Disease — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Severe Osteoporosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: XX Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S t MD

29c. License number: D37934

29d. Date signed (Month, Day, Year): 11/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephanie Trifoglio MD 7500 Greenway Center Drive Greenbelt MD 20770

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999

32. Registrar's Signature: Barbara B. Goodwin

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

(2)

NOV 2 3 1999

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39594

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Frances Elizabeth Finneran

2. Date of Death (Month, Day, Year): December 1, 1999

3. Time of Death: 4:00 PM

4a. Facility Name *(If not institution, give street and number)*: 221 Crocker Drive

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 219-32-1255

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 26, 1915

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 221 Crocker Drive

10f. Zip Code: 21014

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Piano Teacher

16b. Kind of Business/Industry: Self-employed

17. Father's Name *(First, Middle, Last)*: John (UNK) Finneran

18. Mother's Name *(First, Middle, Maiden Surname)*: Jean (UNK) Dick

19a. Informant's Name/Relationship *(Type, Print)*: Virginia G. Seybold/Cousin

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: Echelon Towers, 219 Laurel Road, Apt. 1019 Voorhees, New Jersey 08043

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cematary, crematory or othar placa)*: Dublin Southern Cemetery | Date: 12/6/99

20c. Location - City or Town, State: Darlington, Maryland

21. Signature of Funeral Service Licensee: Kathy A Beagle

22. Name and Address of Facility: McComas Funeral Home, P.A. 21014, 50 W. Broadway & Williams Street, Bel Air, MD

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a: Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARREST — 24 HOURS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: METASTATIC COLON CANCER

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Edwards MD

29c. License number: D31775

29d. Date signed *(Month, Day, Year)*: DECEMBER 3, 1999

30. Name and address of person who completed cause of death (item 23a) (Type, Print): JOHN P. EDWARDS, M.D. 2112 BELAIR ROAD FALLSTON, MARYLAND 21047

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 07 1999

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39595

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): THOMAS THEODORE FORREST
2. Date of Death: Month DEC Day 5 Year 1999
3. Time of Death: 1320
4a. Facility Name (If not institution, give street and number): AVALON MANOR NURSING HOME
4b. City, Town, or Location of Death: HAGERSTOWN
4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 217-10-9188
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUN 3 1914
9. Birthplace (State or Foreign Country): Point of Rocks, Md

Usual Residence of Decedent

10a. State: MD
10b. County: FREDERICK
10c. City, Town or Location: SABILLASVILLE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 17302 HARBAUGH VALLEY RD
10f. Zip Code: 21780
10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): EQUIPMENT OPERATOR
16b. Kind of Business/Industry: PAVING CO

17. Father's Name (First, Middle, Last): THEODORE FORREST
18. Mother's Name (First, Middle, Maiden Surname): LULA BELLE SMITH

19a. Informant's Name/Relationship (Type, Print): M. LYDIA FORREST wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17302 HARBAUGH VALLEY RD, SABILLASVILLE MD 21780

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BROWN'S CEMETERY
Date: DEC 9
20c. Location - City or Town, State: FOXVILLE, MD.

21. Signature of Funeral Service Licensee: James A Bowersox
22. Name and Address of Facility: Grove Funeral Home. Inc 50 S Brood ST Waynesboro Pa 17268

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Multi system Failure	2-3 days
Due to (or as a consequence of): b.	chronic Renal Failure	1 month
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last. Due to (or as a consequence of): c.	Diabetes Mellitus	yrs
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension Arteriosclerotic Cardiovascular Disease Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible] MD
29c. License number: D18019
29d. Date signed (Month, Day, Year): DEC 6, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. VASANT DATTA 334 MILL ST HAGERSTOWN MD 21740

State Registrar

31. Date filed (Month, Day, Year): DEC 06 1999
32. Registrar's Signature: [illegible] G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39596

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edith Adele Nye Frank

2. Data of Death (Month, Day, Year): December 4, 1999

3. Time of Death: 9:45 pm

4a Facility Name (If not institution, give street and number): College View Center

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 327-16-8646

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Feb 25, 1920

9. Birthplace (State or Foreign Country): Michigan

Usual Residence of Decedent

10a. State: West Virginia

10b. County: Jefferson

10c. City, Town or Location: Charles Town

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 681 Tuscawilla Hills

10f. Zip Code: 25414

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Senior Technical Recruiter

16b. Kind of Business/Industry: Aircraft Corporation

17. Father's Name (First, Middle, Last): William Marion Saunders

18. Mother's Name (First, Middle, Maiden Surname): Ethel Rae Saunders

19a. Informant's Name/Relationship (Type, Print): Mr William Frank II/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 681 Tuscawilla Hills, Charles Town, WV 25414

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Calverton Nat'l Cmty | Data: Dec 10,1999

20c. Location - City or Town, State: Calverton, New York

21. Signature of Funeral Service Licensee: Kathryn Bberen M00706

22. Name and Address of Facility: Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. astrocytoma — 3 months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible] MD

29c. License number: D27101

29d. Date signed (Month, Day, Year): 12/6/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lloyd [illegible], 1475 Tung ave, Frederick md 2170[illegible]

State Registrar

31. Date filed (Month, Day, Year): DEC 06 1999

32. Registrar's Signature: [illegible] D. Spaid

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

99-7243-013
DDG
BARRY FITZGERALD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39597

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BARRY JOSEPH FITZGERALD
2. Data of Death (Month, Day, Yaar): DECEMBER 2, 1999
3. Tima of Death: 1830 PM
4a. Facility Name (If not institution, give street and number): 4026 McMULLEN ROAD
4b. City, Town, or Location of Death: TANEYTOWN
4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 212-78-9728
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 39 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 26, 1960
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Taneytown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10a. Street and Number: 4026 McMullen Road
10f. Zip Code: 21787
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yas, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Factory
16b. Kind of Business/Industry: Cabinet Manufacture

17. Father's Name (First, Middle, Last): Joseph Ernest Fitzgerald
18. Mother's Name (First, Middle, Maiden Surneme): Charlotte Bonnie Bowman

19a. Informant's Name/Ralationship (Type, Print): Mother- Charlotte Bonnie Fitzgerald
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 4026 McMullen Rd./ Taneytown, Maryland 21787

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Othar (Specify)
20b. Place of Disposition (Nama of cemetary, crematory or other place): St. Anthonys Cemetery
Data: 12-7-99
20c. Location - City or Town, State: Emmitsburg,Maryland

21. Signature of Funeral Service Licensee: Raymond Peterson
22. Name end Address of Facility: Stauffer Funeral Home 104 E. Main St./ Thurmont, Maryland 21788

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailura. List only one causa on aach lina. (Approximate Intarval Between Onsat and Death)

Immediate Causa (Final disease or condition resulting in death): a. Carbon monoxide intoxication
Dua to (or as a consequence of):
Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or es e consequence ot):
c.
Dua to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause ot death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of daath? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [XX] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [XX] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): 12-2-99
28b. Tima of Injury: unknown M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: subject inhaled exhaust fumes from lawn mower
28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify): Shed behind residence
28f. Location (Street and Number or Rural Route Number, City or Town, State): 4026 McMullen Road Carroll County, Maryland

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [XX] Medical Examiner: On tha basis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, and dua to tha causa(s) and mannar stated.
29b. Signature and title of certifier: Stephen S. Radentz, MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): DECEMBER 3, 1999

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 06 1999
32. Registrar's Signatura: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39598

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET Giles

2. Date of Death: Month November Day 30 Year 1999

3. Time of Death: 9:01PM

4e. Facility Name (If not institution, give street and number): Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 224-70-4981

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 46 Yrs. | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min.

8. Date of Birth (Month, Day, Year): June 18, 1953

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland | 10b. County: Prince George's | 10c. City, Town or Location: Beltsville | 10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 11358 Cherry Hill Road #101 | 10f. Zip Code: 20705 | 10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: UVA Hospital

17. Father's Name (First, Middle, Last): James Washington

18. Mother's Name (First, Middle, Malden Sumeme): Malinda Irving

19a. Informant's Name/Relationship (Type, Print): Florence Martin - Aunt

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): #101 11358 Cherry Hill Rd., Beltsville, MD 20705

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): New Mount Cemetery | Dete: 12/5/99 | 20c. Location - City or Town, State: Nelson Co., VA

21. Signature of Funeral Service Licensee: John T. Stewart, III

22. Name end Address of Feciility: Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

CR

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death): a. Metastatic Carcinoma to liver — 5-6 months

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last:

b. Due to (or es a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

Respiratory Distress

Diabetes Mallitus

23b. Did tobecco uae contribute to the ceuse of deeth? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer) | 28b. Time of Injury M | 28c. Injury et Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Piaca of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

29a. Certifier (Check only one): 1☒ Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date end piece, and due to the cause(s) and manner as steted. 2☐ Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Parmjit MD Attending.

29c. License number: D42580

29d. Date signed (Month, Dey, Yeer): 12-2-99.

30. Name and eddress of person who completed cause of death (item 23a) (Type, Print): PARMJIT S AUJLA. M.D. 5632 Annapolis Rd #13 BLADENSBURG MD 20710.

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999

32. Registrer's Signature

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39599

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Eugene Gregory
2. Data of Death — Month: December; Dey: 2; Yaer: 1999
3. Time of Deeth: 9:45 AM
4a Facility Name (If not institution, give street and number): 7804 Garland Ave.
4b. City, Town, or Location of Deeth: Takoma Park
4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: 217 42 1509
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 54 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Dey, Yeer): Dec. 10, 1944
9. Birthplece (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Takoma Park
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7804 Garland Ave.
10f. Zip Code: 20912
10g. Citizen of Whet Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [XX] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 11; College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Service Technician
16b. Kind of Business/Industry: Heating/Air Condition Contracting

17. Father's Name (First, Middle, Last): Rex Gerald Gregory
18. Mother's Neme (First, Middle, Maiden Surneme): Margaret Gordon

19a. Informant's Name/Relationship (Type, Print): Kathie Gregory / Wife
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 7804 Garland Ave., Takoma Park, MD 20912

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removel from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Plece of Disposition (Neme of cemetery, cremetory or other piece): Chesapeake Crematory Inc. — Dete: 12/3/99
20c. Location - City or Town, Stete: Beltsville, MD

21. Signature of Funeral Service Licensee: Stephen D. Lohrmann
22. Name and Address of Feciliity: Rapp Funeral and Cremation Services, Stephen D. Lohrmann P.A., 933 Gist Ave., Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. — Approximata Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in death): a. Hepatocellular Cancer

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or es e consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Dtd tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one) — Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [XX] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [XX] Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end manner es stated. 2 [ ] Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) and manner steted.

29b. Signature and title of certifier: MD
29c. License number: 0101053358
29d. Date signed (Month, Dey, Yeer): December 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John E. Carroll, M.D., 3028 Javier Rd. #500, Fairfax, VA 22031

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DEC 0 3 1888

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39600

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ellen B Gloyd

2. Date of Death Month: NOV Day: 30 Year: 1999 - 3. Time of Death: 4 30 p.

4a. Facility Name *(If not institution, give street and number)*: Collington Episcopal Life Care Community

4b. City, Town, or Location of Death: Mitchellville

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577 34 1394

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 72 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 9,1927

9. Birthplace *(State or Foreign Country)*: Washington DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Mitchellville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10450 Lottsford Road

10f. Zip Code: 20721

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+): 6+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Registered Nurse

16b. Kind of Business/Industry: Health Care

17. Father's Name *(First, Middle, Last)*: William Gloyd

18. Mother's Name *(First, Middle, Maiden Surname)*: Ellen B.F. Green

19a. Informant's Name/Relationship *(Type, Print)*: Harry R. Smith, Jr. (POA Executor)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6500 Bell Station Rd.Glenn Dale, Maryland 20769

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Placa of Disposition *(Name of cemetery, crematory or other place)*: Lee Crematory

Date: Dec. 1, 1999

20c. Location - City or Town, Stete: Clinton Maryland

21. Signature of Funeral Service Licensee: ▶ Kelli R. Patten

22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton MD 20735

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each iine.

Approximate Intervei Between Onset end Death

Immediate Cause (Finai disease or condition resulting In death)

a. CHRONIC LUNG DISEASE — 10 years

Due to (or es a consequence of):

Sequentlally iist conditions, if any, leeding to immediate cause. Enter Underiying Cause (Disease or Injury that initieted events resulting in death) Last

b. CARDIOMYOPATHY — 10 years

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditione** contributing to death but not resulting In the underiying cause given In Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yee 2☐ No 3☑ Probably 4☐ Unknown

24e. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Mennerof Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)* 1☐ **Certtfying Phyeician:** To the best of my knowiedge, death occurred at the time, dete and piace, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: 20391

29d. Dete signed *(Month, Day, Year)*: NOVEMBER 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR JEFFREY KELMAN, 10650 LOTTSFORD RD, MITCHELLVILLE MD 20721

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

(8)

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 08 1999

32. Registrer's Signature

DHMH 16 Rev 6/95

DEC 0 3 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39601

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Sylvia Ghee
2. Date of Death Month Day Year: November 24,1999
3. Time of Death: 1:30 P.M.
4a Facility Name *(If not institution, give street and number)*: HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-52-8410
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 61 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept.24,1938
9. Birthplace *(State or Foreign Country)*: Wash., D.C.

Usual Residence of Decedent

10a. State:
10b. County:
10c. City, Town or Location: Washington,D.C.
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 144 "W" Street, N.W.
10f. Zip Code:
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Food Service
16b. Kind of Business/Industry: D.C. Government

17. Father's Name *(First, Middle, Last)*: King Joseph McKinney
18. Mother's Name *(First, Middle, Maiden Surname)*: Lucille A. Simpson

19a. Informant's Name/Relationship *(Type, Print)*: Rhoda T. Evans/daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1508 Moffet Road Silver Spring,Md. 20903

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland National Cemetery
Date: 12/3/99
20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: W. J. Jeffries
22. Name and Address of Facility: Frazier's Funeral Home, Inc. 389 Rhode Island Avenue,N.W. Wash.,DC 20001

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Widely metastatic non-small carcinoma — Unknown
Due to (or as a consequence of):
b. Pericardial Effusion — 24 Hours
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Carcinoma Of lung
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Metastatic Carcinoma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Brian F. Reagan MD
29c. License number: D00 45121
29d. Date signed *(Month, Day, Year)*: 11/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Brian F. Reagan Holy Cross Hospital 1500 Forest Glen Ave. Silver Spring,Md.20901

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 01 1999
32. Registrar's Signature: Barbara B. Landi

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39602

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Emma GREEN
2. Date of Death (Month, Day, Year): Nov. 29 1999
3. Time of Death: 8:27 a.m.
4a. Facility Name (If not institution, give street and number): Homewood Retirement Center
4b. City, Town, or Location of Death: Williamsport
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 218-38-1310
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 98 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 13 1901
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Williamsport
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 16505 Virginia Avenue
10f. Zip Code: 21795
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Her own home

17. Father's Name (First, Middle, Last): William Regan Binkley
18. Mother's Name (First, Middle, Maiden Surname): Jessie Lehman

19a. Informant's Name/Relationship (Type, Print): Margaret Kemp - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17720 17720 Crest Drive Hagerstown, Maryland 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rose Hill Cemetery
Date: 12/2/99
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott M Minnich
22. Name and Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

11-29-99 8:27am

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Congestive Heart Failure — yrs

Due to (or as a consequence of): Arteriosclerotic cardiovascular disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

Renal insufficiency

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D26506
29d. Date signed (Month, Day, Year): 11/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AWD, LLC MD 243 Northern Ave Hagerstown MD 21742

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999
32. Registrar's Signature: Dawn G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Green, Helen
Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39603

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY NICKELL GOFF
2. Date of Death (Month, Day, Year): December 2,1999
3. Time of Death: 6:10am
4a. Facility Name (If not institution, give street and number): Civista Medical Center
4b. City, Town, or Location of Death: La Plata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 577-03-4860
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 9,1915
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Charlotte Hall
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12055 Williston Road
10f. Zip Code: 20622
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Legal Office Manager
16b. Kind of Business/Industry: Legal
17. Father's Name (First, Middle, Last): Gilmer Nickell
18. Mother's Name (First, Middle, Maiden Surname): Virginia Garrett
19a. Informant's Name/Relationship (Type, Print): Rex Victor Goff , Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 874 , Waldorf, Maryland 20604
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 12/3/99
20c. Location - City or Town, State: Alexandria,Va.
21. Signature of Funeral Service Licensee: J C Echols FM-00817
22. Name and Address of Facility: AREHART-ECHOLS FUNERAL HOME P.O.Box 567, La Plata, Md. 20646

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ACUTE MYOCARDIAL INFARCTION x 5 Days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. ASYSTOLE with CARDIAC FAILURE. x 2 Hours

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Date of Injury (Month, Day Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: George H. Warthen MD

29c. License number: D20629

29d. Date signed (Month, Day, Year): 12/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): George H. Warthen,MD 11345 Pembrooke Square Suite 103 Waldorf,Maryland20603

State Registrar

31. Date filed (Month, Day, Year): DEC 06 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Mary Goff

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39604

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ashley Mailyn Glynn
2. Date of Death Month Day Year: November 22, 1999
3. Time of Death: 9:37 AM
4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: none
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)* Yrs. / If Under 1 Year Months Days / If Under 24 Hrs. Hours Min.: 2 37
8. Date of Birth *(Month, Day, Year)*: Nov. 22, 1999
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8860 Piney Branch Road, #304
10f. Zip Code: 20903
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 0 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: n/a
16b. Kind of Business/Industry: n/a

17. Father's Name *(First, Middle, Last)*: Marlon J. Glynn
18. Mother's Name *(First, Middle, Meiden Surname)*: Mai Karpo Supper

19a. Informant's Name/Relationship *(Type, Print)*: Mai Karpo Supper (mother)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8860 Piney Branch Road, #304, Silver Spring, MD 20903

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory
Date: 11-27-99
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Carol A Dahm
22. Name and Address of Facility: Rapp Funeral & Cremation Services, Stephen D. Lohrmann, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximete Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pulmonary Insufficiency
Due to (or as a consequence of):
b. Extreme Immaturity
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other signifícent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No
26. Piece of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*: N/A
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated. 2☐ **Medical Examinar:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Matthew B Picard, MD - Attending Physician
29c. License number: Maryland D 0050522
29d. Date signed *(Month, Day, Year)*: 1/22/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Matthew B. Picard, Holy Cross Hospital, Neonatology, 1500 Forest Glen Rd. Silver Spring, MD 20910

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 29 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39605

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ENEDINA GOMEZ
2. Data of Daath (Month, Day, Year): November 29 1999
3. Time of Death: 7:45 AM
4a. Facility Nama (If not institution, giva street and number): Shady Grove Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-62-9753
6. Sax: 1☐ M 2☒ F
7. Aga (In yrs. last birthday): 80 Yrs.
If Undar 1 Yaar: Months / Days
If Undar 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Yaar): Oct. 21, 1919
9. Birthplaca (State or Foreign Country): Spain

Usual Rasidanca of Dacedant

10a. Stata: none
10b. County: none
10c. City, Town or Location: Washington, D.C.
10d. Insida City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4337 Yuma Street, N.W.
10f. Zip Coda: 20016
10g. Citizan of What Country?: Spain
11. Marital Status: 1☒ Navar Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Dacedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Give Yaar or Datas:
13. Was Decedant of Hispanic Orlgin? (Specify Yes or No- If Yes, specify Cuban, Maxicen, Puarto Rican, atc.) 1☐ Yas 2☐ No Specify:
14. Race - Amaricen Indian, Black, White, atc. Specify: white
15. Decedent's Eaucation (Spacify only highest grada completad): Elamantary/Secondary (0-12): 12; Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired): seamstress
16b. Kind of Business/Industry: Lord & Taylor's
17. Fathar's Nama (First, Middla, Last): Justo Gomez
18. Mothar's Nama (First, Middla, Maidan Surnama): Isadora DelCueto
19a. Informant's Name/Ralationship (Typa, Print): Jaime Sanchez/godson
19b. Mailing Address (Straat and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda): 14321 Blackmon Dr., Rockville, Md. 20853
20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Spacify)
20b. Placa of Disposition (Nama of camatary, cramatory or othar placa): Metrolpolian Crematory
Data: Nov. 30, 99
20c. Location - City or Town, Stata: Alex., Va.
21. Signatura of Funaral Sarvica Licensee: James E. DeVol
22. Nama and Addrass of Facility: DeVol Funeral Home, 2222 Wisconsin Ave., N.W., Wash., D.C. 20007

Physician /Medical Examiner

23a. Part I. Entar tha diseasa, or complications that caused tha daath. Do not antar tha moda of dying, such es cardiac or raspiratory errest, shock, or haart failure. List only ona causa on aach lina.

		Approximeta Interval Batwaen Onsat and Daath
Immadiata Causa (Final disaasa or condition rasulting in daath) a.	Cardiac ARRYTHMIA	24 hrs
Dua to (or as a consaquanca of): b.	CORONARY ARTERY DISEASE	10 years
Sequentially list conditions, if any, laading to immadiata ceusa. Entar Underlying Causa (Disease or Injury that initiated avants rasulting in death) Last — Dua to (or as a consaquanca of): c.	HYPERTENSION	10 years
d.		

Part II. **Othar significant conditions** contributing to daath but not rasulting in tha undarlying causa given in Part I.

ADULT ONSET DIABETES MELLITUS
CEREBROVASCULAR DISEASE
CACHEXIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1☐ Yas 2☒ No

25. Was cesa raferred to medical examiner? 1☐ Yas 2☒ No

26. Placa of Daath (Chack only ona): Hospital: 1☒ Inpatient 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending Invastigation 6☐ Could not be datarminad

28a. Data of Injury (Month, Day Yaar)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascriba how injury occurred
28a. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)
28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at the tima, date and place, and due to the cause(s) and menner statad.

29b. Signatura and titla of certifier: W. Sgramma, MD
29c. License number: D 21662
29d. Data signed (Month, Day, Yaar): November 29, 1999

30. Name and addrass of person who complated cause of daath (Itam 23a) (Type, Print): Wilhelmina Camina, M.D. 4912 Adrian St. Rockville MD 20853

State Registrar

31. Data filed (Month, Day, Yaar): DEC 03 1999
32. Ragistrar's Signatura: Geneva B. Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39606

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mattie Stone Gresham
2. Date of Death (Month, Day, Year): November 29, 1999
3. Time of Death: 9:45 am
4a. Facility Name (If not institution, give street and number): 3330 North Leisure World Blvd. #105
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 417-05-1438
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 12, 1912
9. Birthplace (State or Foreign Country): Alabama

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3330 North Leisure World Blvd #105
10f. Zip Code: 20906
10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): | College (1-4or 5+): 2
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Dental Hygenist
16b. Kind of Business/Industry: Medical

17. Father's Neme (First, Middle, Last): Emmaniel Stone
18. Mother's Name (First, Middle, Maiden Surname): Mattie Ramage

19a. Informent's Neme/Reletionship (Type, Print): Edward L. Gresham/ Husband
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3330 North Leisure World Blvd.#105,Silver Spring,MD 20906

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Metropolitan Crematory | Dete: Dec 1 1999
20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: Steven D Strod
22. Neme end Address of Fecility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert tailure. List only one cause on eech line. | Approximete Interval Between Onset and Death

Immediete Cause (Final diseese or condition resulting in deeth): a. Ovarian Carcinoma
Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Last:
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier:
29c. License number: A061438
29d. Date signed (Month, Day, Year): 11/29/99

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Thomas C. Krivak, M.D. 6825 16th St. N.W., Washington, DC 20307

State Registrar

31. Dete filed (Month, Day, Year): DEC 02 1999
32. Registrar's Signeture: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39607

HUBSCHER, MARIE

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marie Ella Hubscher

2. Date of Death: Month NOVEMBER Day 30 Year 1999

3. Time of Death: 8:45 AM

4a. Facility Name (If not institution, give street and number): Doctor's Community Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-48-6429

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min.

8. Date of Birth (Month, Day, Year): Feb. 21, 1936

9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6802 Fairwood Road

10f. Zip Code: 20784

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assistant Cafeteria Manager

16b. Kind of Business/Industry: Public School System

17. Father's Name (First, Middle, Last): John Webber

18. Mother's Name (First, Middle, Maiden Surname): Marie Schmitt

19a. Informant's Name/Relationship (Type, Print): Carl S. Hubscher - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6802 Fairwood Road, Hyattsville, MD 20784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery

Date: 12/4/99

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: ▶ Claudette D. Gasch

22. Name and Address of Facility: Gasch's Funeral Home, 4739 Baltimore Avenue, Hyattsville, MD 20781

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

CR

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CARCINOMA LUNG — 1 mo.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Roger B. Ingham M.D.

29c. License number: D0 5891

29d. Date signed (Month, Day, Year): 12-1-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROGER INGHAM, MD 6510 KENILWORTH AVE SUITE 2400, RIVERDALE, MD 20737

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

(20)

State Registrar

31. Date filed (Month, Day, Year): DEC 02 1999

32. Registrar's Signature: Barbara B. Goodwin

DHMH 16 Rev 6/95

ORIGINAL

DEC 0 2 1999

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39608

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Hortense C. Heitmuller

2. Date of Death Month Day Year: November 23, 1999

3. Time of Death: 5:20 PM

4e Facility Neme *(If not institution, give street and number)*: 1316 Fenwick Lane, #607

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-09-0985

6. Sax: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 103 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 2, 1896

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 1316 Fenwick Lane, #607

10f. Zip Code: 20910

10g. Citizen of What Country?: United States

11. Maritel Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Accountant

16b. Kind of Business/Industry: Office

17. Father's Neme *(First, Middle, Last)*: W. Charles Heitmuller

18. Mother's Name *(First, Middle, Maiden Surname)*: Minna S. Spengler

19a. Informent's Neme/Raletionship *(Type, Print)*: Barbara Boehne (niece)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7016 Sulky Lane, Rockville, Maryland 20852

20e. Method of Disposition: 1☒ Buriel 2☐ Cramation 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rock Creek Cemetery

Date: 11-30-99

20c. Location - City or Town, State: Washington, DC

21. Signature of Funerel Sarvice Licensee: Carol A DeLon

22. Name and Address of Facility: Rapp Funeral & Cremation Services, Stephen D. Lohrman, PA 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one cause on eech line.

Approximata Interval Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in death)

a. Cardiopulmonary Arrest — minutes

Due to (or as s consequence of):

b. Hypertensive Heart Disease — 1 year

Sequentially list conditions, If eny, leeding to immediete cause. Enter Underlying Ceusa (Diseese or injury thet initieted events resulting in death) Last

Due to (or as e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case refarred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Junction MD

29c. License number: D051714

29d. Date signed *(Month, Day, Year)*: November 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jatinder S. Sekhon, M.D., 2401 Research Blvd., Suite 102, Rockville, Maryland 20850

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 01 1999

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours after death.
To the Funeral Director: After this certificata has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DEC 0 1 1998

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39609

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Nicholas Hotton III

2. Date of Death Month Day Year: November 29, 1999

3. Time of Death: 8:05 AM

4e. Facility Name *(If not institution, give street and number)*: 101 Sheridan Ave.

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 380 16 1572

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 28, 1921

9. Birthplace *(State or Foreign Country)*: Michigan

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Montgomery

10c. City, Town or Location: Takoma Park

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 101 Sheridan Ave.

10f. Zip Code: 20912

10g. Citizen of What Country?: United States

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes: WW II

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Paleontologist

16b. Kind of Business/Industry: Research

17. Father's Neme *(First, Middle, Last)*: Nicholas Hotton Jr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Vera Irene Nunnamaker

19e. Informent's Neme/Reletionship *(Type, Print)*: Carol Hotton / Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 101 Sheridan Ave., Takoma Park, MD 20912

20e. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Chesapeake Crematory Inc. | Date: 12/1/99

20c. Location - City or Town, Stete: Beltsville, MD

21. Signature of Funeral Service Licensee: Stephen D Lohrmann

22. Neme end Address of Facility: Rapp Funeral and Cremation Services, Stephen D. Lohrmann P.A., 933 Gist Ave., Silver Spring, MD 20910

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feilure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediete Cause (Finel diseese or condition resulting in deeth): e. Metastatic Adenocarcinoma — one year

Due to (or as e consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest:

b. Adenocarcinoma of Colon — Unknown

Due to (or es a consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: MD

29c. License number: D21531

29d. Date signed *(Month, Day, Year)*: November 30, 1999

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): Dr. Peter G. Pushkas, M.D. 11510 Old Georgetown Rd., Rockville, MD 20852-2736

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed *(Month, Dey, Year)*: DEC 01 1999

32. Registrer's Signeture

DHMH 16 Rev 6/95

ORIGINAL

DEC 0 1 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39610

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mildred N. Hand
2. Date of Death (Month, Day, Year): November 22, 1999
3. Time of Death: 7:20 P.M.

4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-30-2170
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: November 1, 1925
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 622 Blossom Drive
10f. Zip Code: 20850
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Administrative Aide
16b. Kind of Business/Industry: D.C. Public Schools

17. Father's Name *(First, Middle, Last)*: Claude N. Norton
18. Mother's Name *(First, Middle, Maiden Surname)*: Marie Louise Reynolds

19a. Informant's Name/Relationship *(Type, Print)*: Peter Buranich/nephew
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 1119 Falling Waters, WV 25419

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ft. Lincoln Cemetery
Date: Nov. 27, 1999
20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: Susan M Neubert
22. Name and Address of Facility: Ft. Lincoln Funeral Home, 3401 Bladensburg Rd. Brentwood, MD 20722

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Acute renal failure	11 days
Due to (or as a consequence of):	Aug"o gram	11 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — b. Due to (or as a consequence of):		
c.	Peupheral Vascular Disease	12 days
Due to (or as a consequence of):		
d.	Diabetes Mellitis, Type 1	25 years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic PANCREATIS

Pancreatic CARCINOMA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

Medical Certification: To Be Completed by Physician/Medical Examiner

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James F McMurry JR
29c. License number: D30844
29d. Date signed *(Month, Day, Year)*: Nov 23, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES F. McMURRY JR., M.D. 4701 RANDOLPH ROAD, ROCKVILLE, MD

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 30 1999
32. Registrar's Signature: Eugene G. Sands

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Mildred Hand 11/22/99 7:20PM

(12)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39611

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM ALAN HARRIS

2. Date of Death (Month, Day, Year): NOVEMBER 27, 1999

3. Time of Death: 22:15

4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital

4b. City, Town, or Location of Death: BALTIMORE City

4c. County of Death:

Funeral Director

5. Social Security Number: 251-04-2083

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 35 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 30, 1964

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Lutherville

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 801 Kellogg Road

10f. Zip Code: 21093

10g. Citizen of What Country?: United States

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Business Management

16b. Kind of Business/Industry: Peabody Conservatory

17. Father's Name (First, Middle, Last): Moyer L. Harris, Jr.

18. Mother's Name (First, Middle, Maidan Surname): Nancy Wilson

19a. Informant's Name/Relationship (Type, Print): Moyer L. Harris, Jr./Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5011 Smothers Road Westerville, Ohio 43081

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory, Inc.

Date: 11/30/99

20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Laura C. Hardesty

22. Name and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Drive Baltimore, MD 21286

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediata Cause (Final disease or condition resulting in death)

a. Toxoplasmosis — 12 days

Due to (or as a consequence of):

b. Retroviral Syndrome — 6 years

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

Acute renal failure

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)

Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Homa 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at the tima, date end place, and dua to tha causa(s) and manner stated.

29b. Signature and title of certifier: K. Fairbanks MD

29c. License number: RES-000

29d. Data signed (Month, Day, Year): November 27, 1999

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): K. Fairbanks, Johns Hopkins Hospital, Tower 110, 600 North Wolfe Street, Baltimore, Maryland 21287

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

NOV 3 0 1990

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39612

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Leslie Hopkins	Nov. 27, 1999	2:36 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SHADY GROVE ADVENTIST HOSPITAL	ROCKVILLE	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-13-8863	1☐ M 2☒ F	27 Yrs.			March 1, 1972	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Derwood	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7838 Briardale Terrace	20855	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highast grade completed)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	1	Disabled	n/a

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
Richard A. Hopkins, Sr.	Eleanor D. Simpson

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Eleanor Hopkins (mother)	7838 Briardale Terrace, Derwood, Maryland 20855

20a. Mathod of Disposition	20b. Place of Disposition (Neme of cemetery, cramatory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Ash Memorial Cemetery	12-2-99	Sandy Spring, Maryland

21. Signature of Funeral Service Licensee: ▶ Carol a Dehn

22. Name and Address of Facility: Rapp Funeral & Cremation Services, Stephen D. Lohrmann, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications that caused tha death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one causa on aach lina.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last		Approximate Interval Between Onsat and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cerebral Hemorrhage	Days
Due to (or as a consequence of):	b. Cerebral aneurysm	years
Due to (or as e consequence of):	c.	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yas 2☒ No	1☐ Yas 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only ona)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Mannar of Death	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding Investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of *my* knowledge, death occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at tha tima, data and placa, and dua to tha cause(s) and mannar stated.

29b. Signature and title of certifier	29c. License number	29d. Data signed (Month, Day, Year)
▶ Alan S Chanales MD	29453	November 28, 1999

30. Name and address of parson who complated causa of death (Item 23a) (Type, Print): ALAN S. CHANALES MD, 15215 SHADY GROVE RD ROCKVILLE MD 20850

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 30 1999	Barbara B. Goode

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

NOV 3 0 1988

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39613

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VONZILE H. HILL
2. Date of Death: Month Nov Day 28 Year 99
3. Time of Death: 5:05 AM
4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-22-1522
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 9/16/13
9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: Md.
10b. County: P.G.
10c. City, Town or Location: Chapel Oaks
10d. Inside City Limits: ☒Yes 2☐No
10e. Street and Number: 5017 Nash Street
10f. Zip Code: 20743
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒No Specify:
14. Reca - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Money Presser
16b. Kind of Business/Industry: Treasury Dept. U.S. Government

17. Father's Name (First, Middle, Last): Fletcher Hunt
18. Mother's Name (First, Middle, Maiden Surname): Annie Crow

19a. Informant's Name/Relationship (Type, Print): Sadie Freeman/Cousin
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 114 Larsdale Rd.,Buffalo,N.Y. 14208

20a. Method of Disposition: ☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lincoln Mem. Cem. Date: 12/2/99
20c. Location - City or Town, State: Suitland, Md.

21. Signeture of Funeral Servica Licensee: Gary W. Pratt
22. Name and Address of Facility: H.S.Washington & Sons Co.,Inc. 4925 Burroughs Ave.,N.E.,Wash.,D.C. 20019

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert faiture. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. Acute Peritonitis — 7 days
Due to (or as a consequence of):
b. Rourrent intra abdominal Haemhage — 7 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Possible Sepsis — 7 days
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
Cancer of Colon Post resection
Cardiac Arythmias

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred et the time, date end place, end due to the cause(s) and menner steted.
29b. Signature and title of Certifier: M.D
29c. License number: D 24721
29d. Date signed (Month, Day, Year): 11/28/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SYED SADIQ, 14333 Laurel Bowie Rd. Laurel MD 20708

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999
32. Registrer's Signature: Beverly A. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

99-7090-033
DDG
GARY HOPKINS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39614

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GARY ALBERT HOPKINS, JR.
2. Date of Death (Month, Day, Year): NOVEMBER 27, 1999
3. Time of Death: 0259 AM
4a. Facility Name (If not institution, give street and number): DOCTORS HOSPITAL
4b. City, Town, or Location of Death: LANHAM
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 218-21-8337
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 19 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 5, 1980
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Lanham
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 9707 Woodberry Street
10f. Zip Code: 20706
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 1yr.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: Private
17. Father's Name (First, Middle, Last): Gary Albert Hopkins, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Marion Gray
19a. Informant's Name/Relationship (Type, Print): Marion Hopkins/Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9707 Woodberry Street, Lanham, Maryland 20706
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery | Date: 12/01 1999
20c. Location - City or Town, State: Brentwood, Maryland
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

CR

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Gunshot Wound of chest
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): 11-27-99
28b. Time of Injury: 0224 M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: subject shot
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): street
28f. Location (Street and Number or Rural Route Number, City or Town, State): 8501 Goodluck Road
29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): NOVEMBER 27, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

(6)

State Registrar

31. Date filed (Month, Day, Year): DEC 01 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

DEC 01 1998

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39615

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY HAWKINS

2. Date of Death (Month, Day, Year): November 25, 1999

3. Time of Death: 3:00 p.m.

4a. Facility Name (If not institution, give street and number): 6201 Springhill Drive #203

4b. City, Town, or Location of Death: Greenbelt

4c. County of Death: Prince Georges'

Funeral Director

5. Social Security Number: 578-48-6938

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 12, 1936

9. Birthplace (State or Foreign Country): Rollingfork, Miss

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges'

10c. City, Town or Location: Greenbelt

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6201 Springhill Drive #203

10f. Zip Code: 20770

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homecare Provider

16b. Kind of Business/Industry: Private Industry

17. Father's Name (First, Middle, Last): John W. Bullocks

18. Mother's Name (First, Middle, Maiden Surname): Annie Pearl Taylor

19a. Informant's Name/Reletionship (Type, Print): George Hawkins/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6201 Springhill Dr. #203 Greenbelt, Md. 20770

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Nat'l Harmony Memorial Pk

Date: 11/30/99

20c. Location - City or Town, State: Landover, Maryland

21. Signature of Funeral Service Licensee: W. J. Jeffers

22. Name and Address of Facility: Frazier's Funeral Home, Inc. 389 R.I. Ave., N.W. Wash., DC 20001

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line.

Approximete Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. multple myeloma — 5 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

b. Renal Failure

Due to (or as a consequence of):

c. Bleeding

Due to (or as a consequence of):

d.

Part fl. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jon L Hopkins

29c. License number: 010105 1742

29d. Date signed (Month, Day, Year): 11/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Hopkins, MD 8901 Wisconsin Avenue Bethesda, Maryland 20889-5000

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999

Registrar's Signature: Barbara B. Saxton

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

20

NOV 2 9 1999

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39616

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Jane Herbert

2. Dete of Death: Month November Day 27 Year 1999

3. Time of Death: 2 10 pm.

4a Facility Name *(If not institution, give street and number)*: Doctors Hospital

4b. City, Town, or Location of Deeth: Lanham

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 577-60-8463

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 53 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Year)*: July 1, 1946

9. Birthplece *(Stete or Foreign Country)*: Wash. D.C.

Usual Residence of Decedent

10a. State: Md.

10b. County: Prince Georges

10c. City, Town or Location: Bowie

10d. Inside City Limits: 1☐ Yes 2☐ No XX

10e. Street and Number: 16505 Ariel Court

10f. Zip Code: 20716

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: School bus driver

16b. Kind of Business/Industry: County Gov't

17. Father's Name *(First, Middle, Last)*: Thomas L. Oliff

18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Rosalie Rose

19a. Informant's Name/Reletionship *(Type, Print)*: Larry M. Herbert - husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 16505 Ariel Court, Bowie, Md. 20716

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: Resurrection Cemetery

Date: 11-30-99

20c. Location - City or Town, Stete: Clinton, Md.

21. Signature of Funeral Service Licensee: Shannon W. Beall

Shannon W. Beall M00798

22. Name and Address of Feciility: Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Md. 20715

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other then 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Mary Jane Herbert

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart tailure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Finet disease or condition resulting in death)

a. Recurrent aspiration Pneumonia — 5 days

Due to (or es e consequence of):

b. Binswanger's Disease — 5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as e consequence of):

c.

Due to (or as e consequence of):

d.

Part tt. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

Breast cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Neturat 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: D Granite MD

29c. License number: D17572

29d. Dete signed *(Month, Dey, Year)*: 11/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Granite MD 115 Centerway Greenbelt, MD 20770

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State Registrar

31. Date filed *(Month, Day, Year)*: NOV 29 1999

32. Registrar's Signature: Barbara B. Lewis

DHMH 16 Rev 6/95

ORIGINAL

NOV 2 3 1988

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39617

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert C. Heitman
2. Date of Death (Month, Day, Year): November 25, 1999
3. Time of Death: 10:52PM
4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 220-38-4122
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 60 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 16, 1939
9. Birthplace (State or Foreign Country): California

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Temple Hills
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 4716 Temple Hill Road
10f. Zip Code: 20748
10g. Citizen of What Country?: USA
11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5+ College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Technical Writer
16b. Kind of Business/Industry: Private Industry
17. Father's Name (First, Middle, Last): William L. Heitman,Jr.
18. Mother's Name (First, Middle, Maiden Surname): Laura Florence Hooser
19a. Informant's Name/Relationship (Type, Print): William L. Heitman,Jr/Father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as item 10
20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 11/27/99
20c. Location - City or Town, State: Alexandria,Va.
21. Signature of Funeral Service Licensee: George P. Kalas
22. Name and Address of Facility: George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill,Md. 20745

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Metastatic Colon Cancer
Due to (or as a consequence of):
Multiple Organ Failure

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and Title of certifier
29c. License number: D46312
29d. Date signed (Month, Day, Year): November 26, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Vincent Okeke, M.D. 3710 Riviera St. Temple Hills,Md. 20748 Suite 1A

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NOV 2 0 1998

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39618

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DAVID W. HOWARD

2. Date of Death: Month 11 Day 20 Year 99

3. Time of Death: 5:30 PM

4a. Facility Name (If not institution, give street and number): HARTLAND HEALTH CARE CENTER

4b. City, Town, or Location of Death: HYATTSVILLE

4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 578-82-8574

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 34 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 4, 1965

9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Suitland

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3516 Silver Park Drive

10f. Zip Code: 20747

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 3yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Automation Clerk

16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Pheroneus Howard

18. Mother's Name (First, Middle, Maiden Surname): Rosemary Muldrow

19a. Informant's Name/Relationship (Type, Print): Rosemary Howard/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 500 North Harry S. Truman Drive, Upper Marlboro, MD 20774

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Glenwood Cemetery

Date: 11/24/1999

20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: J.B. JENKINS FUNERAL HOME, 7474 Landover Road, Landover, Maryland 20785

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIO RESPIRATORY FAILURE

Due to (or as a consequence of):

b. ACQUIRED IMMUNE DEFICIENCY SYNDROME

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. SEIZURES

Due to (or as a consequence of):

d. CVA

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D42019

29d. Date signed (Month, Day, Year): 11/24/1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Imran Chowdhury, M.D., 7350 Van Dusen Road, #220, Laurel, Maryland 20707

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999

32. Registrar's Signature: [signature] B. Frank

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NOV 2 9 1995

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39619

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ceola Harvell
2. Date of Death (Month, Day, Year): November 23 1999
3. Time of Death: 7:25 a.m.
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 245 22 7363
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 17, 1917
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State:
10b. County:
10c. City, Town or Location: Washington DC
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4311 15th Street NW
10f. Zip Code: 20011
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Pennsylvania Railroad

17. Father's Name (First, Middle, Last): Joseph Grier
18. Mother's Name (First, Middle, Maiden Surname): Martha Graham

19a. Informant's Name/Relationship (Type, Print): Mary Lewis daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14020 Northwyn Dr. Silver Spring, MD 20904

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lincoln Cemetery
Date: 11-27
20c. Location - City or Town, State: Suitland, Maryland

21. Signature of Funeral Service Licensee: J. P. Marshall
22. Name and Address of Facility: MARSHALL'S FUNERAL HOME OF MD 4308 Suitland Road Suitland, MD 20746

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Sepsis	4 days
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Respiratory failure	4 days
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Anuradha Mendiratta MD
29c. License number: D38262
29d. Date signed (Month, Day, Year): Nov 23, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dr Anurita Mendiratta 2401 Research BLVD Suite 240 Rockville MD 20854

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999
32. Registrar's Signature: [signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39620

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Redding Harvey III

2. Date of Death Month / Day / Year: December 5 1999

3. Time of Death: 1754

4a. Facility Name *(If not institution, give street and number)*: Fallston General Hospital

4b. City, Town, or Location of Death: Fallston

4c. County of Death: Harford

Funeral Director

5. Social Security Number: None

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Mar. 8, 1926

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Forest Hill

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1914 Crouse Road

10f. Zip Code: 21050

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Farmer

16b. Kind of Business/Industry: Agricultural Farming

17. Father's Name *(First, Middle, Last)*: William Redding Harvey, Jr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Slade Pearce

19a. Informent's Name/Reletionship *(Type, Print)*: Hazel V. Harvey / Wife

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1914 Crouse Rd., Forest Hill, Maryland 21050

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Bel Air Memorial Gardens | Date: 12-9-99

20c. Location - City or Town, Steta: Bel Air, Maryland

21. Signature of Funeral Service Licensee: Howard K. McComas

22. Name and Address of Facility: McComas Funeral Home,P.A. 50 W. Broadway St., Bel Air, Maryland 21014

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feilure. List only one cause on eech line. | Approximete Intervel Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in death)
a. Intestinal Obstruction
Due to (or as a consequence of):
b. Massive Inguinal Hernia
Due to (or es a consequence of):
c.
Due to (or es a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Arteriosclerotic Heart Disease
Sepsis
Severe Dehydration

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)* | 28b. Time of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) and menner steted.

29b. Signature and title of certifier: Willard P. Amos

29c. License number: D0004354

29d. Date signed *(Month, Day, Year)*: December 5, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Willard P. Amoss, 2303 Belair Rd, Fallston, Md 21047

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 07 1999

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Harvey, William 73/m 1754

2

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39621

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lester William Hann

2. Date of Death: Month DECEMBER Day 3 Year 1999

3. Time of Death: 1:05 PM

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 204-03-6299

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jun.28,1920

9. Birthplace (State or Foreign Country): Pa.

Usual Residance of Decedent

10a. Steta: Pa.

10b. County: Fulton

10c. City, Town or Location: Harrisonville

10d. Inside City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Number: 316 Buck Rd.

10f. Zip Code: 17228

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No If Yas, Giva Yaar or Datas: W W II

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highast grade completed): Elamentary/Secondary (0-12): 8 College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired): Maintenance

16b. Kind of Businass/Industry: Pa. Turnpike Auth.

17. Fathar's Nama (First, Middle, Last): Carl Glenn Hann

18. Mothar's Nama (First, Middle, Maiden Sumama): Julia Blanche Mumma

19a. Informant's Name/Ralationship (Type, Print): Vera Hann/ wife

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 316 Buck Rd. Harrisonville, Pa. 17228

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Place of Disposition (Nama of cemetary, crematory or other place): Asbury United Meth. Cemetery

Data: 12/5

20c. Location - City or Town, Stata: Harrisonville,Pa

21. Signature of Funeral Service Licensaa: Lionel C. Burner MBE

22. Nama and Addrass of Facility: Burner Trade Services 1037 Dual Place Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Entar tha diseasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on each lina.

Approximate Interval Between Onset and Death

Immediata Causa (Final disaasa or condition resulting in daath)

a. Carcinoma of Colon With Metastasis — 6 Months

Dua to (or as a consequence of):

Sequantially list conditions, if eny, laading to immediata causa. Entar Undarlying Cause (Disaase or injury thet initiated avants resulting in daath) Last

b.

Dua to (or as a consequence of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa given in Part I.

History of Lung Cancer.
History of Carcinoma Neck.
Chronic obstructive Lung Diseasease

23b. Did tobacco use contributs to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [ ] No

24b. Wara autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [ ] No

25. Was casa rafarrad to medical examinar? 1 [ ] Yas 2 [X] No

26. Place of Death (Check only ona): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Homa 5 [ ] Residence 6 [ ] Other (Specify)

27. Mannar of Death: 1 [ ] Natural 2 [ ] Accidant 3 [ ] Sulcida 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be datarmined

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28b. Tima of Injury

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28e. Data of Injury (Month, Day Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifiar (Check only one): 1 [X] **Certifying Physician**: To tha best of my knowledga, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner**: On tha basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and place, and due to tha cause(s) and mannar stated.

29b. Signatura and title of certifier: M.D.

29c. License number: D 18127

29d. Data signed (Month, Day, Year): 12/3/99

30. Nama and addrass of parson who completed causa of death (Item 23a) (Type, Print): C. C. Su. M.D. 370 Mill St. Hagerstown Md. 21740

State Registrar

31. Data filed (Month, Day, Year): DEC 06 1999

32. Registrar's Signatura: G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

LESTER HANN

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39622

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jennifer Harne
2. Date of Death Month / Day / Year: November 30 1999
3. Time of Death: 7:35pm
4a. Facility Name *(If not institution, give street end number)*: THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-11-7080
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 21 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 7 1978
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Pennsylvania
10b. County: Franklin
10c. City, Town or Location: Greencastle
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13718 Worleytown Road
10f. Zip Code: 17225
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 0-12 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Data Entry
16b. Kind of Business/Industry: Merchant Services

17. Father's Name *(First, Middle, Last)*: James Victor Harne
18. Mother's Name *(First, Middle, Maiden Surname)*: Carol Trumpower

19a. Interment's Name/Relationship *(Type, Print)*: Carol D. Keckler - Mother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13718 Worleytown Road Greencastle, Pa. 17225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cedar Lawn Memorial Park — Date: 12/4/99
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott Minnich
22. Name and Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. respiratory failure — 20 minutes
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. cystic fibrosis — 21 years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: rejection of transplanted lungs

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Lisa Sanders
29c. License number: RES-000
29d. Date signed *(Month, Day, Year)*: November 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lisa Sanders Md 600 North Wolfe St. Baltimore, MD 21287

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 03 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39623

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Effie Josephine Harsh

2. Date of Death: Month November Day 25 Year 1999

3. Time of Death: 1608

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 218-50-2624

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 94 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): August 10, 1905

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Williamsport

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 128 East Potomac Street

10f. Zip Code: 21795

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Rollie Amma Ansparger

18. Mother's Name (First, Middle, Maiden Surname): Sarah Lucretia Eccard

19a. Informant's Name/Relationship (Type, Print): Martin D. Harsh Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7721 River Rock Ct. Williamsport, MD 21795

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Greenlawn Memorial Park Date: 11-29-99

20c. Location - City or Town, State: Williamsport, Maryland

21. Signature of Funeral Service Licensee: Dorf E Osborne

22. Name and Address of Facility: Osborne Funeral Home 425 South Conococheague Street Williamsport, Maryland 21795

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. CONGESTIVE HEART FAILURE — Approximate Interval Between Onset and Death: YEARS

Due to (or as a consequence of):
b. ASTHMATIC BRONCHITIS — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and Title of certifier: D Woolstenhulme MD

29c. License number: D22643

29d. Date signed (Month, Day, Year): 11/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 11110 MEDICAL CAMPUS RD #130 HAGERSTOWN MD

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Effie J. Harsh

Dr. Woolstenhulme

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39624

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Minnie L. Hardy
2. Dete of Deeth: Month 12 Dey 01 Yeer 99
3. Time of Deeth: 2:55 P.M
4e. Feclity Neme *(If not institution, give street end number)*: 3916 South Mountain Road
4b. City, Town, or Location of Deeth: Knoxville
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 220-30-9948
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs. (If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.)
8. Dete of Birth *(Month, Dey, Yeer)*: Jan 7, 1915
9. Birthplece *(State or Foreign Country)*: Brunswick MD

To Be Completed by Funeral Director

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Frederick
10c. City, Town or Location: Knoxville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 3916 South Mountain Road
10f. Zip Code: 21718
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indien, Bleck, White, etc. *Specify:* Negro

15. Decedent's Eduction *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 7; College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife
16b. Kind of Business/Industry: Homemaker

17. Fether's Neme *(First, Middle, Last)*: David Spriggs
18. Mother's Name *(First, Middle, Maiden Surname)*: Marie Nicholas

19a. Informent's Name/Reletionship *(Type, Print)*: Sandra E. Hardy, Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1521 Morris Road, S.E., Washington, DC 20020

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Plece of Disposition *(Name of cemetery, crematory or other place)*: Resthaven Memorial Gardens
Dete: 12/6
20c. Location - City or Town, Stete: Frederick, MD

21. Signature of Funeral Service Licensee: Barbara A. Williams
Barbara A. Williams, Owner
22. Neme end Address of Feclity: John T. Williams Funeral Home
100 Petersville Road, Brunswick, MD 21716

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Deeth

Immediate Ceuse (Final disease or condition resulting in death): e. Metastatic pancreatic cancer — long standing
Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Lest:
b. Due to (or es e consequence of):
c. Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cauee of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Plece of Deeth *(Check only one)*: Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 8☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*: NA
28b. Time of Injury: NA M
28c. Injury et Work? 1☐ Yes 2☐ No NA
28d. Describe how injury occurred: NA.
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*: NA
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*: NA

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner steted.

29b. Signeture and title of certifier:
29c. License number: D47169
29d. Date signed *(Month, Day, Year)*: 12/2/99

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Ma Chan-Hing Ho, 610 Ninth Avenue, Brunswick, MD 21716

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 06 1999
32. Registrer's Signeture: Donna G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

DHMH 16 Rev 6/95

99-7113-033
B.K.S
CAROL ANDREA HALL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39625

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carole Andrea Hall
2. Date of Death (Month, Day, Year): NOV. 28, 1999
3. Time of Death: 8:45 AM
4a. Facility Name (If not institution, give street and number): ROUTE#210 & 495 OUTERLOOP
4b. City, Town, or Location of Death: OXON HILL
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 053-60-0940
6. Sex: 1☐ M 2☒ F XX
7. Age (In yrs. last birthday): 47 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 14, 1952
9. Birthplace (State or Foreign Country): Canada

Usual Residence of Decedent

10a. State: NY
10b. County: Suffolk
10c. City, Town or Location: East Northport
10d. Inside City Limits: 1☐ Yes 2☐ No XX
10e. Street and Number: 5 Elsmere Place
10f. Zip Code: 11731
10g. Citizen of What Country? Canada

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): School Bus Monitor
16b. Kind of Business/Industry: Transportation

17. Father's Name (First, Middle, Last): Maurice Hovington
18. Mother's Name (First, Middle, Maiden Surname): Gabrielle Bouchard

19a. Informant's Name/Relationship (Type, Print): Marion Hall - Mother-in-law
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 Elsmere Place East Northport, NY 11731

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Rood Cemetery
Date: 12/4/99
20c. Location - City or Town, State: Westbury, New York

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Capitol Funeral Service, Inc. 5517 Vine Street Alexandria, VA 22310

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Multiple Injuries
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? XX Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6XX Other (Specify) AT SCENE

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): 11-28-99
28b. Time of Injury: 0824 M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: passenger auto - auto collision
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Roadway
28f. Location (Street and Number or Rural Route Number, City or Town, State): I 495

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. XX☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): NOV. 29, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year): DEC 03 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

99-7112-033
B.K.S
JOHN MICHAEL HALL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39626

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last)	2. Dete of Death (Month, Dey, Year)	3. Time of Death
John Michael Hall	NOV. 28, 1999	0847 AM

4a Facility Neme (If not institution, give street end number)	4b. City, Town, or Location of Death	4c. County of Death
ROUTE#210 & 495 OUTERLOOP	OXON HILL	PRINCE GEORGES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Year)	9. Birthplace (Stete or Foreign Country)
114-44-3596	XX 1 M 2 F	47 Yrs.			July 20, 1952	New York

Usuel Residence of Decedent

10a. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
NY	Suffolk	East Northport	XX 1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5 Elsmere Place	11731	USA

11. Merital Stetus	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Black, White, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	1 Yes 2 XX No If Yes, Give Yeer or Detes:	1 Yes 2 XX No Specify:	Specify: White

15. Decedent's Education (Specify only highest grede completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	Collega (1-4or 5+) 2	Technical Support Specialist	Computer Operations

17. Father's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Sumeme)
Howard Hall	Marion Leary

19e. Informent's Neme/Reletionship (Type, Print)	19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
Marion Hall - Mother	5 Elsmere Place East Northport, NY 11731

20e. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1 X Burieł 2 Cremetion 3 Removal from Steta 4 Donetion 5 Other (Specify)	Holy Rood Cemetery	12/4/99	Westbury, New York

21. Signature of Funeral Service Licensee: Karen L. Woodsell

22. Neme and Address of Fecility: Capitol Funeral Service, Inc. 5517 Vine Street Alexandria, VA 22310

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on eech line.

		Approximete Interval Between Onset and Death
Immediate Cause (Final diseese or condition resulting in deeth)	a. Multiple Injuries	
	Due to (or as e consequence of):	
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest	b.	
	Due to (or es e consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 X Yes 2 No	1 X Yes 2 No

25. Wes case referred to medical examiner?	26. Place of Deeth (Check only one)	
XX Yes 2 No	Hospitel: 1 Inpetient 2 ER/Outpetient 3 DOA	Other: 4 Nursing Home 5 Residence XX Other (Specify) AT SCENE

27. Menner of Deeth	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 Neturel 2 X Accident 3 Suicide 4 Homicide 5 Pending investigetion 6 Could not be determined	11-28-99	0824 M	1 Yes 2 X No	Driver auto - auto collision

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify): Roadway

28f. Location (Street end Number or Rural Route Number, City or Town, Stete): I 495

29e. Certifier (Check only one): 1 **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end menner es stated. XX **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner stated.

29b. Signeture end title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	O.C.M.E	NOV. 29, 1999

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Year)	32. Registrer's Signeture
DEC 03 1999	Renee G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39627

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SOON HI HAN

2. Date of Death (Month, Day, Year): NOVEMBER 29, 1999

3. Time of Death: 10:00 A.M.

4a. Facility Name (If not institution, give street and number): HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 214-08-7408

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAR. 21, 1921

9. Birthplace (State or Foreign Country): KOREA

Usual Residence of Decedent

10a. State: MD

10b. County: MONTGOMERY

10c. City, Town or Location: POTOMAC

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10809 OLD COACH ROAD

10f. Zip Code: 20854

10g. Citizen of What Country?: UNITED STATES OF AMERICA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: KOREAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): HON KYON HAN

18. Mother's Name (First, Middle, Maiden Surname): SI KIM

19a. Informant's Name/Relationship (Type, Print): PETER H. YUN/SON-IN-LAW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10809 OLD COACH ROAD POTOMAC, MARYLAND 20854

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): IL SAN CHRISTIAN CEM. Date: 12/4/99

20c. Location - City or Town, State: SEOUL, KOREA

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. GASTRIC CARCINOMA

Due to (or as a consequence of):

DIABETES MELLITUS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD for P. Murphy MD

29c. License number: D0052695

29d. Date signed (Month, Day, Year): 11/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D McPhee, MD Holy Cross Hosp ER / 1500 Forest Glen Rd / SS. MD 20910

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39628

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Francis Hennigan, Sr.

2. Date of Death Month Day Year: November 24, 1999

3. Time of Death: 2:05 PM

4a. Facility Name (If not institution, give street and number): Montgomery Village Care & Rehabilitation

4b. City, Town, or Location of Death: Montgomery Village

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-20-0501

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 8, 1925

9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 711 Owens Street

10f. Zip Code: 20850

10g. Citizen of What Country?: United States

11. Meritel Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1943/1946

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): | College (1-4or 5+): 2

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Contractor

16b. Kind of Business/Industry: Self Employed

17. Father's Neme (First, Middle, Last): James M. Hennigan

18. Mother's Name (First, Middle, Maiden Sumeme): Anna Dudas

19a. Informent's Name/Relationship (Type, Print): Elizabeth A. Hennigan/Wife

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 711 Owens Street, Rockville, Maryland 20850

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other place): St. Mary's Cemetery

Date: 11/29/99

20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name end Address of Feclility: DeVol Funeral Home 10 E. Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert fellure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final diseese or condition resulting in death) a.	Sepsis	1 week
Due to (or es e consequence of): b.	traumatic brain hemorrhage	years
Sequentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Lest — Due to (or es a consequence of): c.		
Due to (or es e consequenca of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

diabetes,
peripheral vascular disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical exeminer? 1 ☐ Yes 2 ☒ No

26. Place of Deth (Check only one) — Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Deeth: 1 ☐ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigetion 6 ☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and manner steted.

29b. Signature and title of certifier: John R Melnick MD

29c. License number: D19294

29d. Date signed (Month, Day, Year): November 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John R. Melnick, M.D., 911 Russell Avenue Gaithersburg, MD 20879

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999

32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

1041

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39629

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Ann Hensley
2. Date of Death Month / Day / Year: November 22, 1999
3. Time of Death: 4:30 AM
4a. Facility Name *(If not institution, give street and number)*: Crescent Cities Center
4b. City, Town, or Location of Death: Riverdale
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 229-26-9769
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 2, 1916
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Riverdale
10d. Inside City Limits: 1☒ Yes 2☐ No
10a. Street and Number: 4409 East West Highway
10f. Zip Code: 20737
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Executive Assistant
16b. Kind of Business/Industry: Conrail Railroad

17. Father's Name *(First, Middle, Last)*: William A. Fox
18. Mother's Name *(First, Middle, Meiden Surname)*: Mary Belle Haley

19a. Informent's Neme/Reletionship *(Type, Print)*: Sanders Fox Haley (nephew)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2810 Woodstock Avenue, Silver Spring, MD 20910

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Chesapeake Crematory
Date: 11-26-99
20c. Location - City or Town, Stete: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Carol A. Dehn
22. Name and Address of Facility: Rapp Funeral & Cremation Services
Stephen D. Lohrmann, P.A.
933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediate Cause (Final diseese or condition resulting in deeth): e. Pneumonia — 4 days

Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last:
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No
26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: Renee
29c. License number: D19609
29d. Date signed *(Month, Day, Year)*: 11-22-99

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): Raman R. Tuli, M.D., 3503 Perry Street, Suite B, Mt Rainier, MD 20712

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 29 1999
32. Registrar's Signature: Renee G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39630

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Evelyn Ippolito

2. Data of Death Month / Day / Year: November 29, 1999

3. Time of Death: 3:19 pm

4a. Facility Name *(If not institution, give street and number)*: 17905 Hickory Lane

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 030-18-6154

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: June 15, 1914

9. Birthplace *(State or Foreign Country)*: Canada

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 17905 Hickory Lane

10f. Zip Code: 21740

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 3

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: nurse

16b. Kind of Business/Industry: hospital

17. Father's Name *(First, Middle, Last)*: Edward J. Flanagan

18. Mother's Name *(First, Middle, Maiden Surname)*: Helen Graham

19a. Informant's Name/Relationship *(Type, Print)*: Robert G. Ippolito - son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12260 Corte Sabio, Unit 5210, San Diego CA 92128

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Florida National Cemetery — Date: 12/6/99

20c. Location - City or Town, State: Bushnell, Florida

21. Signature of Funeral Service Licensee: Scott Minnich

22. Name and Address of Facility: MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Carcinoma cervix — 4 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*: NA

28b. Time of Injury: NA M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: NA

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: NA

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: NA

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gloria F. Pura MD

29c. License number: D19824

29d. Date signed *(Month, Day, Year)*: Dec. 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GLORIA F. PURA 366 MILL ST HAGERSTOWN MD 21740

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 06 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39631

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret Isbell

2. Date of Death (Month, Day, Year): December 3, 1999

3. Time of Death: 7:35 pm

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 066-16-1723

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10-24-20

9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8218 Virginia Lane

10f. Zip Code: 21704

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Social Worker

16b. Kind of Business/Industry: Catholic Church

17. Father's Name (First, Middle, Last): Samuel Wilson Murray

18. Mother's Name (First, Middle, Maiden Surname): Margaret NMI Turnbull

19a. Informant's Name/Relationship (Type, Print): Kenneth Isbell (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8218 Virginia Lane, Frederick, Maryland 21704

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory | Date: 12/4/99

20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: Robert E. Dailey

22. Name and Address of Facility: Robert E. Dailey & Son F.H.P.A. 1201 N. Market Street, Frederick, Maryland 21701

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CEREBRAL VASCULAR ACC. DENT — 1 MO.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION, DIABETES MELLITUS, DEMENTIA, ARRHYTHMIA, CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Andrew O. Donelson MD

29c. License number: D21936

29d. Date signed (Month, Day, Year): 12/4/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANDREW DONELSON MD 170 THOMAS JOHNSON DRIVE SUITE 100, FREDERICK 21702

State Registrar

31. Date filed (Month, Day, Year): DEC 06 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39632

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LESSIE JOHNSON
2. Date of Death: Month Nov Day 30 Year 99
3. Time of Death: 10:44AM
4a. Facility Name (If not institution, give street and number): Prince George's Hospital
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 424-60-6581
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 56 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 1, 1943
9. Birthplace (State or Foreign Country): Alabama

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Forestville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6445 Hil Mar Drive #102
10f. Zip Code: 20747
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Examiner
16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Willie Johnson
18. Mother's Name (First, Middle, Maiden Surname): Mollie Mae Lee

19a. Informant's Name/Relationship (Type, Print): Rodney Johnson - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2810 - 5th St., S.E., #303, Wash., D.C. 20032

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lee's Crematory
Date: Dec.6,99
20c. Location - City or Town, State: Clinton, MD

21. Signature of Funeral Service Licensee: John T. Stewart, III
22. Name and Address of Facility: Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Probable Acute Myocardial Infarction	2-3 hrs
Due to (or as a consequence of): b.	Coronary Artery Disease	75 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.	Sepsis	10-12 days
Due to (or as a consequence of): d.	Pneumonia	12-12 days

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

End Stage Renal Disease
Neuropathy
Chronic Lung Disease

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Phyaicien:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.
29c. License number: D13957
29d. Date signed (Month, Day, Year): 12/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JASWINDER S. SIDHU, 7525 Greenway Center Dr., Greenbelt MD 20770

State Registrar

31. Date filed (Month, Day, Year): DEC 02 1999
32. Registrar's Signature:

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DEC 0 5 1988

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39633

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SADIE JOHNSON
2. Date of Death (Month, Day, Year): NOVEMBER 23, 1999
3. Time of Death: 11:30 pm
4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 240 186 416
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 16, 1914
9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1215 Gleneagle Road
10f. Zip Code: 21239
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Beautician
16b. Kind of Business/Industry: Self-Employed

17. Father's Name (First, Middle, Last): Ira A. Williams
18. Mother's Name (First, Middle, Maiden Surname): Wilmer Scott

19a. Informant's Name/Relationship (Type, Print): Louis Johnson/ son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1215 Gleneagle Road Baltimore, Maryland 21239

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount Cemetery | Date: 11/30/99
20c. Location - City or Town, State: Philadelphia, PA

21. Signature of Funeral Service Licensee: Laura C. Hardesty
22. Name and Address of Facility: CAFA Stephen D. Lohmann P.A. 8717 Green Pastures Drive Baltimore, Maryland 21286

CR

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. RESPIRATORY FAILURE
Due to (or as a consequence of):
b. CHRONIC PLEURAL EFFUSION.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. PNEUMONIA.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.
29b. Signature and title of certifier: Manisha Bahl, M.D.
29c. License number: P13452
29d. Date signed (Month, Day, Year): NOVEMBER 23, 1999.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MANISHA BAHL, GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN BLVD, BALTIMORE, MD 21239-2995.

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(3)

NOV 3 0 1993

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39634

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lisa Marjorie James

2. Date of Death Month Day Year: November 23, 1999

3. Time of Death: 2:50pm

4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery County

Funeral Director

5. Social Security Number: 578-82-1396

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 30 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 12, 1969

9. Birthplace (State or Foreign Country): Jamaica

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Germantown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 19029 Larksong Tr.

10f. Zip Code: 20874

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Rupert James

18. Mother's Name (First, Middle, Maiden Surname): Vertentis Lynch

19a. Informant's Name/Relationship (Type, Print): Vertentis James/ Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10350 Royalwood Ct. Gaithersburg, Md. 20886

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery | Date: 11/30/99

20c. Location - City or Town, State: Silver Spring, Md.

21. Signature of Funeral Service Licensee: Keith A. Hanagan MIOBS

22. Name and Address of Facility: Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747

Physician /Medical Examiner

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. INTRACRANIAL HEMORRHAGE	12 hours
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ACUTE LEUKEMIA	1 week
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Carl L Schoenberger MD

29c. License number: D 26540

29d. Date signed (Month, Day, Year): NOV 23 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Carl L. Schoenberger 16220 Frederick Rd Gaithersburg MD

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999

32. Registrar's Signature: Barbara B. Sanders

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

NOV 3 0 1999

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39635

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen Hoover Jenkins
2. Date of Death (Month, Day, Year): November 28, 1999
3. Time of Death: 4:10 AM
4a. Facility Name *(If not institution, give street and number)*: Collington Life Care Center
4b. City, Town, or Location of Death: Mitchellville
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 157-30-2481
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 92 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 2, 1906
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Mitchellville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10450 Lottsford Road
10f. Zip Code: 20721
10g. Citizen of Whet Country?: United States

11. Maritat Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: George Hoover
18. Mother's Name *(First, Middle, Maiden Surname)*: Meena C. Doub

19a. Informant's Name/Relationship *(Type, Print)*: Pamela Jenkins Licht (daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 4405 Clearbrook Lane, Kensington, Maryland 20895

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Chesapeake Crematory
Dete: 11-30-99
20c. Location - City or Town, Stete: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Carola Dehn
22. Name and Address of Facility: Rapp Funeral & Cremation Services, Stephen D. Lohrmann, PA 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such es cardiac or respiretory errest, shock, or heart tailure. List only one cause on eech line. — Approximete Intarval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death): a. Aspiration Pneumonia — 2 days

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or es a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa referred to medicat examiner? 1☐ Yas 2☒ No
26. Place of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Dascribe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, death occurred at the time, date and place, end dua to the causa(s) end manner as statad. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, date and place, and dua to the cause(s) and manner stated.

29b. Signeture end title of certifier: [signature] MD
29c. License number: D25079
29d. Date signed *(Month, Day, Year)*: November 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Don H. Yabonowitz, MD, 7404 Executive Place, #502, Seabrook, MD 20706

State Registrar

31. Data filed *(Month, Day, Year)*: NOV 30 1999
32. Registrar's Signatura: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

NOV 3 0 1994

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39636

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Akins Jahi Jones

2. Date of Death: Month November Day 26 Year 1999

3. Time of Death: 6:40 AM

4a. Facility Name (If not institution, give street and number): Prince George's Hospital Center

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: none

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): Yrs. | If Under 1 Year: Months | Days 5 | If Under 24 Hrs.: Hours | Min.

8. Date of Birth (Month, Day, Year): Nov. 21, 1999

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Germantown

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 12542 Laurel Grove Place

10f. Zip Code: 20874

10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): infant

16b. Kind of Business/Industry: infant

17. Father's Name (First, Middle, Last): Alex Jones

18. Mother's Name (First, Middle, Maiden Surname): Juliette Cathleen Brookes

19a. Informant's Name/Relationship (Type, Print): Juliette Cathleen Brookes (mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12542 Laurel Grove Place, Germantown, Maryland 20874

20a. Method of Disposition: 1 [ ] Buriat 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory

Date: 11-27-99

20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Carol a Dehn

22. Name and Address of Facility: Rapp Funeral & Cremation Services, Stephen D. Lohrmann, PA 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one cause on each line.

Approximate Intervel Between Onset and Death

Immediate Ceuse (Finet diseese or condition resulting in death)

a. Overwhelming Sepsis (Group B Strep)

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pulmonary Hypertension Severe

Due to (or as a consequence of):

c. Prematurity

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner ot Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete ot Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: Wilma Dayrit M.D.

29c. License number: D-234628

29d. Date signed (Month, Day, Year): November 26, 1999

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): Wilma Dayrit, M.D., 3001 Hospital Drive, Cheverly, MD 20785

State Registrar

31. Date filed (Month, Day, Year): NOV 3 0 1999

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

MAR 3 0 1995

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39637

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Benjamin E. Justice

2. Data of Death Month Day Year: Nov. 24, 1999

3. Time of Death: 12:28AM

4a. Facility Name *(If not institution, give street and number)*: Prince Georges Hospital

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: P.G.

Funeral Director

5. Social Security Number: 577-28-3480

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: April 25, 1922

9. Birthplace *(State or Foreign Country)*: N.C.

Usual Residence of Decedent

10a. State: MD.

10b. County: P.G.

10c. City, Town or Location: Forestville

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 7420 Marlboro Pike

10f. Zip Code: 20747

10g. Citizen of What Country?: United States

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 1943 1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cleaning Spotter

16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Frank Justice

18. Mother's Name *(First, Middle, Maiden Surname)*: Fannie Jenkins

19a. Informant's Name/Relationship *(Type, Print)*: Gwendolyn Byrd/niece

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9514 Gwynndale Drive Clinton, MD. 20735

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MD. Veterans Cem.

Date: 11/30/99

20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: Leroy Hodges

22. Name and Address of Facility: Hodges & Edwards F.H. 3910 Silver Hill Road Suitland, MD.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. pneumonia

Due to (or as a consequence of):

c. hypernatremia

Due to (or as a consequence of):

d. dehydration

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

dementia

CVA

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Meera Ranhouwa

29c. License number: D52222

29d. Date signed *(Month, Day, Year)*: NOV. 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ranhouwa, Meera 3001 Hospital Drive Cheverly, MD.

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 29 1999

32. Registrar's Signature

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

NOV 2 3 1993

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39638

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Doris Johnson
2. Date of Death (Month, Day, Year): November 30 1999
3. Time of Death: 22:30
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 217-12-2937
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 15, 1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: PA.
10b. County: Franklin
10c. City, Town or Location: Greencastle
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 157 South Carlisle St.
10f. Zip Code: 17225
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Charles Lowery
18. Mother's Name (First, Middle, Maiden Surname): Helen Hummelsine

19a. Informant's Name/Relationship (Type, Print): Terry G. Johnson /Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3581 Brook St. Greencastle, Pa. 17225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): Cedar Hill Cemetery
Date: 12/4/99
20c. Location - City or Town, State: Greencastle, Pa.

21. Signature of Funeral Service Licensee: H. Martin Zimmerman Jr.
22. Name and Address of Facility: Zimmerman And Son Funeral Home Inc. 45 S. Carlisle St. Greencastle, Pa.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardio-pulmonary arrest
Due to (or as a consequence of):
b. respiratory failure s/p tracheostomy
Due to (or as a consequence of):
c. pneumonia
Due to (or as a consequence of):
d. end stage renal disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
ANCA positive vasculitis
atrial fibrilation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: B4 6111 827
29d. Date signed (Month, Day, Year): 12/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): YANPING YU 12931 Oak Hill Avenue. Hagerstown. MD 21742

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Doris Yvonne Johnson

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): DEC 06 1999
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39639

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Alice Jenkins
2. Data of Death Month Dey Yaar: December 3, 1999
3. Time of Death: 1:00 P.m.
4a. Facility Name (If not institution, give street and number): Charles County Nursing Center
4b. City, Town, or Location of Death: LaPlata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 215-44-3950
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 96 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): Oct. 18, 1903
9. Birthplece (State or Foreign Country): Maryland

Usuel Residence of Decedent

10e. Stete: Maryland
10b. County: Charles
10c. City, Town or Location: LaPlata
10d. Insida City Limits: 1☒ Yas 2☐ No
10e. Street end Number: 10200 LaPlata Road
10f. Zip Code: 20646
10g. Citizen of Whet Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Dacedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Give Yaer or Detas:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, atc.): 1☐ Yes 2☒ No Specify:
14. Rece - Americen Indien, Bleck, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed): Elementery/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): John Allen Wenk
18. Mother's Neme (First, Middle, Meidan Sumama): Mary Anna Jenkins

19a. Informent's Name/Relationship (Type, Print): Lucille J. Dyson/Daughter
19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stata, Zip Code): P.O. Box 942, LaPlata, Maryland 20646

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): St. Mary's Cemetery
Dete: Dec. 7, 1999
20c. Location - City or Town, Stete: Bryantown, Maryland

21. Signeture of Funeral Service License: JOHN P. KNISLEY M01164
22. Name and Address of Facility: The Huntt Funeral Home, Inc. P.O. Box 156, Waldorf, Maryland 20604

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complications thet caused the deeth. Do not entar tha moda of dying, such as cardiac or raspiratory arrasl, shock, or heart feilure. List only one ceuse on eech line.

Approximata Intervel Between Onset end Death

Immediate Ceuse (Finel diseese or condition resulting in deeth)
a. Senile deterioration — 2 years
Due to (or es a consequence of):
Sequentielly list conditions, if eny, leeding to immedieta ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Last
b. advanced age.
Due to (or es e consequance of):
c.
Due to (or es e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☑ No
24b. Ware autopsy findings eveilable prior to completion of causa of deeth? 1☐ Yas 2☐ No

25. Was casa referred to medicel examiner? 1☐ Yes 2☑ No

26. Piece of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined
28e. Dete of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, streel, fectory, office building, atc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: F.M. Johnson M.D.
29c. License number: D06704
29d. Dete signed (Month, Dey, Yaer): 12-3-99

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): F.M. JOHNSON MD PO BOX 460 LAPLATA MD 20646

State Registrar

31. Dete filed (Month, Dey, Yaer): DEC 06 1999
32. Registrar's Signeture: Denise B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

mew

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39640

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Norma Jackson
2. Date of Death (Month, Day, Year): December 1, 1999
3. Time of Death: 5:50 pm

4a. Facility Name (If not institution, give street and number): Casey House 6001 Muncaster Mill Road
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-03-2184
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 4, 1916
9. Birthplace (State or Foreign Country): DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Adelphi
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10416 Glenmore Drive
10f. Zip Code: 20783
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Norman Clifton Howe
18. Mother's Name (First, Middle, Maiden Surname): Mary Del Tufo

19a. Informant's Name/Relationship (Type, Print): Dick Jackson / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 Granby Court, Derwood, MD 20855

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: 12/03/99
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Tracy A. Stuver
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd,. W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic colon cancer	less than 3 months
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Renal mass	less than 3 months
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Hyperthyroidism

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Linda M Burrell MD
29c. License number: D35996
29d. Date signed (Month, Day, Year): December 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Linda Burrell, MD 2101 Medical Park Dr., #210, Silver Spring, MD 20902

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999
32. Registrar's Signature: Laura B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 396411

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert G. Jenkins

2. Date of Death Month Day Year: November 27, 1999

3. Time of Death: 11:15 PM

4a. Facility Name *(If not institution, give street and number)*: Springhouse

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-38-8347

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 96 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 12, 1903

9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedant

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4925 Battery Lane #903

10f. Zip Code: 20814

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Bleck, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machinist

16b. Kind of Business/Industry: U.S. Government

17. Fathar's Nama *(First, Middla, Last)*: Maner Jenkins

18. Mother's Nama *(First, Middla, Maiden Sumema)*: Minnie Beck

19a. Informant's Name/Ralationship *(Type, Print)*: Margaret J. Betts/Daughter

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 5225 Pooks Hill Rd.#1122N, Bethesda, Maryland 20814

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramovel from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Name of cematary, crematory or other place)*: Montgomery Crematorium, Inc.

Data: Nov. 29, 1999

20c. Location - City or Town, Stete: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Ray Lee

M00198

22. Nama and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Entar the disaasa, or complications that causad tha daath. Do not entar tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximata Intervel Between Onset and Death

Immediata Causa (Final disease or condition resulting in death)

a. Congestive Heart Failure — 3 months

Dua to (or as a consequence of):

Sequantially list conditions, if eny, leeding to immadiata cause. Entar Underlying Cause (Disaase or injury that initiated evants resulting in death) Last

b. Coronary Artery Disease

Dua to (or as a consequence of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Tuberculosis

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was case refarred to medical examinar? 1☒ Yas 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☐ Residenca 6☒ Othar *(Specify)* Assisted Living

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be determined

28a. Place of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Date of Injury *(Month, Day Year)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To tha best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and mannar as steted. 2☐ **Medical Examiner**: On tha basis of axamination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and mannar stated.

29b. Signatura and title of certifiar: Marvin Fuchs MD

29c. License number: 13284 DC

29d. Data signed *(Month, Day, Year)*: 11/29/99

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print): Marvin Fuchs, M.D. 5315 Connecticut Avenue, N.W., Washington, D.C. 20015

State Registrar

31. Data filed *(Month, Day, Year)*: NOV 30 1999

32. Registrar's Signatura: Geneva G. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39642

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Frances Minnick Keefe
2. Date of Death Month Day Year: November 29, 1999
3. Time of Death: 6:15 PM
4e. Facility Name *(If not institution, give street and number)*: 10110 Meredith Avenue
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-24-0592
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 30, 1920
9. Birthplace *(State or Foreign Country)*: Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10110 Meredith Avenue
10f. Zip Code: 20910
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Florist
16b. Kind of Business/Industry: Flower Shop
17. Father's Name *(First, Middle, Last)*: Ezra Minnick
18. Mother's Name *(First, Middle, Maiden Surname)*: Effie U. Pence
19a. Informant's Name/Relationship *(Type, Print)*: JoAn Keefe (daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10110 Meredith Avenue, Silver Spring, MD 20910
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory | Date: 12/1/99
20c. Location - City or Town, State: Beltsville, Maryland
21. Signature of Funeral Service Licensee: Carol A Dehn
22. Name and Address of Facility: Rapp Funeral & Cremation Services, Stephen D. Lohrmann, PA 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart teilure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Progressive Cerebral Thrombosis — 12 Hours

Due to (or as e consequence of):
Hypertensive Cardiovascular Disease — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
b. Due to (or as e consequence of):
c. Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Lung Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No
25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, atreet, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner steted.
29b. Signature and title of certifier
29c. License number: D26331
29d. Dete signed *(Month, Day, Year)*: November 30, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Marta Anne Schneider, M.D., 5401 McArthur Blvd.,NW, Washington D.C. 20016-2523

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 01 1999
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DEC 01 1988

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39643

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rosetta Kelley
2. Date of Death (Month, Day, Year): November 24 1999
3. Time of Death: 1030 PM
4a. Facility Name (If not institution, give street and number): Prince Georges Hospital Center
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 577-52-8931
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): December 11, 1937
9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Lanham
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 8423 Hamlin Street
10f. Zip Code: 20706
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Waitress
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Isiah Workman
18. Mother's Name (First, Middle, Maiden Surname): Nellie Settles

19a. Informant's Name/Relationship (Type, Print): Sayan Kelley/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8423 Hamlin Street, Lanham, Maryland 20706

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Memorial Park
Date: 12/02 1999
20c. Location - City or Town, State: Landover, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. End Stage liver disease
Due to (or as a consequence of):
b. Gastrointestinal bleeding
Due to (or as a consequence of):
c. Renal failure
Due to (or as a consequence of):
d. Hypotensive shock.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hepatic encephalopathy

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: D51006
29d. Date signed (Month, Day, Year): November 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J.D. Alleyne, M.D 3001 Hospital Dr Cheverly MD 20875

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

5

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39644

Amend # 8.& 10c.Per Fam. PGC 11-29-99 cr

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Andrew Koznowsky

2. Date of Death (Month, Day, Year): NOVEMBER 24 1999

3. Time of Death: 8:04 A.M.

4a. Facility Name (If not institution, give street and number): MALCOLM GROW MEDICAL CENTER

4b. City, Town, or Location of Death: CAMP SPRINGS

4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 200 - 16- 4818

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): ~~October 18, 1929~~ Aug. 13, 1924

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: ~~Tempel Hills~~ Temple Hills

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3800 Mattaews DR.

10f. Zip Code: 20748

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Military

16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): George Koznowsky

18. Mother's Name (First, Middle, Malden Sumeme): Julia Melnick

19a. Informent's Neme/Reletionship (Type, Print): Barbara Bricker/ Daughter

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): Rt. 186 Prospect Harbor, ME 04669

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other place): Geo. Wash. University Medical Center

Date: November 25,1999

20c. Location - City or Town, Stete: Washington , D.C.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Columbia Mortuary Services, Inc. P.O. Box 58007 Washington,D.C. 20037

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

29a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Deeth
Immediate Cause (Final disease or condition resulting in death)	a. GASTRIC CANCER	3 WEEKS
Due to (or as a consequence of):	b. NOSOCOMIAL PNEUMONIA	1 WEEK
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or es a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted. 2 [ ] **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D0053640 MD

29d. Date signed (Month, Dey, Yeer): NOVEMBER 24 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHRISTOPHER A ROSEBERRY,MAJ,USAF,MC

89MDG/1050 W PERIMETER RD ANDREWS AIR FORCE BASE, MD 20762-6600

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

(10)

State Registrar

31. Dete filed (Month, Dey, Yeer): NOV 29 1999

32. Registrer's Signature: [signature]

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NOV 2 8 1988

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39645

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert Henry Kerby

2. Date of Death Month Day Year: November 24, 1999

3. Time of Death: 9:20pm

4a. Facility Name *(If not institution, give street and number)*: FORT WASHINGTON HOSPITAL

4b. City, Town, or Location of Death: Fort Washington

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 219-42-2545

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 29, 1938

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Ft. Washington

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8407 Indian Head Highway

10f. Zip Code: 20744

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4 or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Self-employed

16b. Kind of Business/Industry: Farming

17. Father's Name *(First, Middle, Last)*: C.H. Brooke Kerby

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Bertha Moreland

19a. Informant's Name/Relationship *(Type, Print)*: Jacqueline Kerby/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: Same as item 10

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Ignatius Church Cem.

Date: 11/30/99

20c. Location - City or Town, State: Fort Washington, Md.

21. Signature of Funeral Service Licensee: G. P. Kalas

22. Name and Address of Facility: George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cirrhosis, Alcohol

Due to (or as a consequence of):

b. Hepatorenal syndrome

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Ascites

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D3G 156

29d. Date signed *(Month, Day, Year)*: 11/25/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph R. Murphy MD 10270 Old Ln Ct #200 Waldorf MD

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 29 1999

32. Registrar's Signature: B. Hanes

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Robert Henry Kerby

cr

15

NOV 23 1959

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39646

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Valinda Kim Nurse Kirksey

2. Date of Death Month Day Year: Nov. 22, 1999

3. Time of Death: 12:55pm

4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-78-7037

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 42 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 10, 1957

9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: Md

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2122 Randolph Road

10f. Zip Code: 20902

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify*: Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 3

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Disbursement Officer

16b. Kind of Business/Industry: Educational Funding Dept.

17. Father's Name *(First, Middle, Lest)*: Chanley Nurse

18. Mother's Name *(First, Middle, Meiden Surneme)*: Joyce Willis

19e. Informant's Name/Relationship *(Type, Print)*: Joyce & Chanley Nurse/Parents

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 2122 Randolph Road, Silver Spring, Md 20902

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cametery, cremetory or other placa)*: Seaside Crematory | Date: 11/29/99

20c. Location - City or Town, State: Palermo, New Jersey

21. Signature of Funeral Service Licensee: Philip D Rinaldi

22. Name end Address of Facility: Philip D. Rinaldi Funeral Service 11818 New Hampshire Ave, Silver Spring, Md.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. | Approximate Intervel Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):
b. Respiratory failure
Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last
Due to (or as a consequence of):
c. Pancreatitis
Due to (or as a consequence of):
d. Immunocompromised host

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Ovarian Cancer, Breast Cancer

23b. Did tobacco uae contribute to the cauaa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Death *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: ☒ 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es stated. ☐ 2 **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D 23170

29d. Date signed *(Month, Dey, Year)*: 11/26/99

30. Neme end eddress of person who completed cause of death (Item 23a) (Type Print): DR. RAVI PASSI, MD 1500 FOREST GLEN RD, SILVER SPRING, MD 20910

State Registrar

31. Date filed *(Month, Dey, Year)*: NOV 29 1999

32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

(2)

NOV 2 3 1988

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39647

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lottie E Kareiva
2. Data of Death (Month, Day, Year): Nov. 26, 1999
3. Time of Death: 8:15 A.M.
4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 041-20-7188
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Apr.26,1917
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Md.
10b. County: Anne Arundel
10c. City, Town or Location: Crofton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1603 Edgerton Place
10f. Zip Code: 21114
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Reca - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Computer Operator
16b. Kind of Business/Industry: Navigational researc

17. Fathar's Nama (First, Middle, Last): Alexander Jakucewicz
18. Mothar's Nama (First, Middle, Maidan Surnama): Lottie Burdyn

19a. Informant's Name/Relationship (Type, Print): Frank D. Kareiva - husband
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 1603 Edgerton Place, Crofton, Md. 21114

20a. Mathod of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from Stete 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Name of cematary, crematory or other place): St. Marys Cemetery
Date: 12-01-99
20c. Location - City or Town, Stata: Dickson City, PA.

21. Signatura of Funaral Service Licensee: ▶ Robert G. Beall M00025
22. Nama and Address of Facility: Beall Funeral Home, 6512 N.W. Crain Hwy., Bowie, Md. 20715

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona cause on each line. — Approximata Intervel Betwaan Onset end Death

Immedieta Cause (Finel disaasa or condition rasulting in death)
a. Dehydration — 2days
Due to (or as a consequence of):
b. Colon Cancer — 8 months

Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last
Dua to (or es a consequence of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Ware autopsy findings available prior to complation of causa of death? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at tha tima, date and placa, end due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or Investigation, in my opinion, death occurred at tha tima, deta end piece, and due to the ceusa(s) and mannar stated.

29b. Signatura and title of certifier: ▶ Jeanine Werner
29c. Licansa number: D52830
29d. Data signad (Month, Day, Year): November 26, 1999

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): Jeanine Werner 900 Bestgate Road, Annapolis, MD 21401

State Registrar

31. Data filed (Month, Day, Year): NOV 2 9 1999
Registrar's Signatura:

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by tha funeral director, page 2 should be detached for use as the burial-transit

NOV 2 9 1999

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39648

Kaercher, Robert Charles
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Charles Kaercher
2. Date of Death: Month December Day 3 Year 1999
3. Time of Death: 3:23AM
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington County

Funeral Director

5. Social Security Number: 157-14-1553
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 75 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 24, 1924
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington Co.
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13525 Paradise Church Road
10f. Zip Code: 21742
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 02/23/43 12/08/45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Photographer
16b. Kind of Business/Industry: Truck Manufacturing

17. Father's Name (First, Middle, Last): Charles Frederick Kaercher
18. Mother's Name (First, Middle, Maiden Surname): Rosemary Olive McNamara

19a. Informant's Name/Relationship (Type, Print): Deborah Anne Williams/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1325 Outer Drive, Hagerstown, Maryland 21742

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rest Haven Cemetery
Date: Dec.6
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Douglas A. Fiery
22. Name and Address of Facility: Douglas A. Fiery Funeral Home 1331 Eastern Blvd.N.,Hagerstown,Maryland 21742

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multifocal Brain
Due to (or as a consequence of):
b. Sepsis — 3-4 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Congestive Heart Failure Atrial Fibrillation
Chronic Renal insufficiency chronic obstructive Pulmonary Disease Carcinoma Prostate

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D18019
29d. Date signed (Month, Day, Year): Dec 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Datta 334 Mill Street Hagerstown Maryland

State Registrar

31. Date filed (Month, Day, Year): DEC 06 1999
32. Registrar's Signature: Geneva G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39649

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Edward KOVACICH

2. Date of Death (Month, Day, Year): December 1, 1999

3. Time of Death: 7:11PM

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 210-09-5804

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 18, 1913

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 516 North Mulberry Street

10f. Zip Code: 21740

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Foundry worker shop grinder

16b. Kind of Business/Industry: sand blasting

17. Father's Name (First, Middle, Last): Joseph Kovacich

18. Mother's Name (First, Middle, Maiden Surname): Cecelia unknown

19a. Informant's Name/Relationship (Type, Print): Delores J. Harner - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1269 Woodland Parkway, Waynesboro, Pa. 17268

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from Stete 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Rest Haven Cemetery | Date: 12-4-99

20c. Location - City or Town, Stete: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott M Kamich

22. Name and Address of Facility: MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death)

a. Acute Myocardial Infarction — 48 hours

Due to (or es e consequence of):

b. and Shock

Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

Due to (or es a consequence of):

c. and Acute And Chronic Renal Failure

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Edward W Ditto

29c. License number: D01062

29d. Date signed (Month, Day, Year): December 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edward W. Ditto, III M.D. 217 W. Washington St. Hagerstown, Md 21740

State Registrar

31. Date filed (Month, Day, Year): DEC 06 1999

32. Registrar's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit copy.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39650

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JAMES WILSON KONTRA

2. Data of Death (Month, Day, Year): November 24, 1999

3. Time of Death: 8:40 PM

4a. Facility Name *(If not institution, give street and number)*: WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death: HAGERSTOWN

4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 208-48-0319

6. Sex: 1☐ M 2☐ F — X

7. Age *(In yrs. last birthday)*: 30 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)

8. Data of Birth *(Month, Day, Year)*: OCT. 18, 1969

9. Birthplace *(State or Foreign Country)*: PENNSYLVANIA

Usual Residence of Decedent

10a. State: WV

10b. County: BERKELEY

10c. City, Town or Location: MARTINSBURG

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 404 PENN STREET

10f. Zip Code: 25401

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yas 2☐ No. If Yes, Give Year or Dates: 12/2/87 TO 1/3/96

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elemantary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: NETWORK CONTROL

16b. Kind of Business/Industry: GTE

17. Father's Nama *(First, Middle, Last)*: ANDREW KONTRA

18. Mother's Nama *(First, Middle, Maiden Surname)*: SANDRA RAHM

19a. Informent's Neme/Reletionship *(Type, Print)*: JULIE J. KONTRA/WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 404 PENN STREET, MARTINSBURG, WV 25401

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: PLEASANT VIEW MEM. GDS. — Date: 11/27/99

20c. Location - City or Town, State: MARTINSBURG, WV

21. Signature of Funaral Service Licensee: ▶ Charles M. Brown

22. Nama and Address of Facility: BROWN FUNERAL HOME, 327 W. KING ST. PO BOX 821, MARTINSBURG, WV 25402

Physician /Medical Examiner

23a. Part1. Entar tha disaase, or complications thet caused the death. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, shock, or heert failura. List only one cause on each line. — Approximala Interval Between Onset and Death

Immediata Causa (Final disease or condition rasulting in death)
a. Multiple Head Trauma — Hours

Due to (or as a consequence of):
b. motor vehicle accident

Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last
Due to (or es a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other signiticant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was casa refarred to medical examinar? 1☒ Yas 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☐ Rasidence 6☐ Othar *(Specify)*

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*: Nov 24 99

28b. Time of Injury: 1:15 PM

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: collision w/ 18 wheeler

28e. Place of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*: In Tennessee 70E

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 28 mile marker E. INTERSTATE 70

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☒ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at tha tima, data and place, and due to tha cause(s) and manner steted.

29b. Signature and title of certifier: ▶ H. N. Weeks Med

29c. License number: D0011266

29d. Date signed *(Month, Dey, Year)*: Nov 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): H. N. Weeks 580 Northern Av Hagerstown, MD 21742

State Registrar

31. Deta filed *(Month, Day, Year)*: DEC 03 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Kontra James Wilson

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39651

Amend #1, 12/8/99, BMW, Montg. Co.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eleanora R. Kalie -Czoper

2. Date of Death: Month November Day 25 Year 1999

3. Time of Death: 1401

4a. Facility Name (If not institution, give street and number): 11913 Coronada Pl

4b. City, Town, or Location of Death: Kensington

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-26-5620

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 27, 1924

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11913 Coronada Pl

10f. Zip Code: 20895

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Reca - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 12

College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: National Bureau of Standards

17. Fether's Neme (First, Middle, Lest): John Kalie

18. Mother's Neme (First, Middle, Meiden Surneme): Margaret Miazga

19a. Informent's Neme/Relationship (Type, Print): Dorothea L. Agnew/Daughter

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 12910 New Hampshire Ave, Silver Spring, MD 20904

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other pleca): Gate of Heaven Cemetery

Dete: Nov 29

20c. Location - City or Town, Stete: Silver Spring, MD

21. Signature of Funeral Service Licensee: Alan J Donnell

22. Name end Address of Facility: Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feilure. List only one cause on each line.

Approximate Intervel Between Onset and Deeth

Immedlete Ceuse (Final diseese or condition resulting in death)

a. ASCVD — DME

Due to (or es e consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initieted events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☒ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) end menner stated.

29b. Signature and title of certifier: Ira N Brecher MD DME

29c. License number: D00425

29d. Dete signed (Month, Dey, Year): Nov 22, 1999

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): IRA N. BRECHER, MD DME 2101 medical Park Dr Silver Spring MD 20902

State Registrar

31. Dete filed (Month, Day, Year): NOV 29 1999

32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

11/29/99 (see #31)
Incorrect date 11/26/99 Applied. White out used +
11/29/99 Applied. B. McWilliams

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39652

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Raymond Keany

2. Date of Death (Month, Day, Year): November 24, 1999

3. Time of Death: 2:09 PM

4a. Facility Name (If not institution, give street and number): Maplewood Park Place Health Care

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 010-07-4939

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 14, 1905

9. Birthplace (State or Foreign Country): Massachusetts

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9707 Old Georgetown Road, #1402

10f. Zip Code: 20814

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: World War II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): - | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Washington, D.C. Representative

16b. Kind of Business/Industry: Petroleum Company

17. Father's Name (First, Middle, Last): Peter Keany

18. Mother's Name (First, Middle, Maiden Surname): Katherine Connelley

19a. Informant's Name/Relationship (Type, Print): Virginia W. Keany/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9707 Old Georgetown Rd., #1402, Bethesda, MD 20814

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc

Date: Nov. 26, 1999

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: M00689

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Alzheimer's Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D26259

29d. Date signed (Month, Day, Year): November 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ava A. Kaufman, M.D. 4930 Del Ray Avenue, #403, Bethesda, Maryland 20814

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

15+1

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39653

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joan Booth Kelly

2. Date of Death (Month, Day, Year): November 28, 1999

3. Time of Death: 2:15 PM

4a. Facility Name (If not institution, give street and number): Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-36-2679

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 29, 1931

9. Birthplace (State or Foreign Country): Kansas

Usual Residence of Decedent

10a. State: North Carolina

10b. County: Chatham

10c. City, Town or Location: Pittsboro

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 502 Fearrington Post

10f. Zip Code: 27312

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Arch N. Booth

18. Mother's Name (First, Middle, Maiden Surname): Wilma Harrison

19a. Informant's Name/Relationship (Type, Print): John D. Kelly/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 502 Fearrington Post, Pittsboro, North Carolina 27312

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.

Date: Nov. 29, 1999

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Ronald Funk M00198

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.
7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumococcal Pneumonia — 5 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Adult Respiratory Distress Syndrome

Renal Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sigvard Beck, MD

29c. License number: D 46052

29d. Data signed (Month, Day, Year): 11/28/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sigvard Beck, MD 8600 Old Georgetown Road, Bethesda, MD 20814

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1415 Jw 11/28/99 Kelly, Joan 20

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39654

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William A. Kelly
2. Date of Death (Month, Day, Year): December 2, 1999
3. Time of Death: 4:30 AM
4a. Facility Name (If not institution, give street and number): Woodside Center
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 271-16-4897
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 15, 1907
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 9101 Second Avenue
10f. Zip Code: 20901
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-1960
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Retired Officer
16b. Kind of Business/Industry: US Army

17. Father's Name (First, Middle, Last): John Kelly
18. Mother's Name (First, Middle, Maiden Surname): Adaline Coffman

19a. Informant's Name/Relationship (Type, Print): Carol Skolnik
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11831 Charles Road, Silver Spring, MD 20906

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National Cemetery | Date: 12/15/1999
20c. Location - City or Town, State: Arlington, VA

21. Signature of Funeral Service Licensee: Eric S. Scalo
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Aspiration Pneumonia — 2 days
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Renal Failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D37975
29d. Date signed (Month, Day, Year): December 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeffrey P. Indrisano, M.D. 10801 Lockwood Dr., Ste 280, Silver Spring, MD 20901

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39655

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FRANK A. KENYON
2. Date of Death Month / Day / Year: NOVEMBER 24, 1999
3. Time of Death: 8:30AM
4a. Facility Name *(If not institution, give street and number)*: HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-10-1478
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: AUG. 26, 1915
9. Birthplace *(State or Foreign Country)*: WASHINGTON, DC

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1131 UNIVERSITY BLVD. WEST
10f. Zip Code: 20902
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MANUFACTURERS REPRESENTITIVE
16b. Kind of Business/Industry: PAINT AND HARDWARE

17. Father's Name *(First, Middle, Last)*: FRANK KENYON
18. Mother's Name *(First, Middle, Maiden Surname)*: LAURA KOENIG

19a. Informant's Name/Relationship *(Type, Print)*: JOHN KENYON/SON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2017 LUZERNE AVENUE SILVER SPRING, MD 20910

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CEDAR HILL CEMETERY
Date: 11/30/99
20c. Location - City or Town, State: SUITLAND, MD

21. Signature of Funeral Service Licensee: Arthur S. DiMeo
22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE SILVER SPRING, MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. CONGESTIVE HEART FAILURE — DAYS

Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. ARTERIOSCLEROSIS

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
NON INSULIN DEPENDENT DIABETES MELLITUS
RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No [X] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Al Jawad Waqas. M.D.
29c. License number: D0052931
29d. Date signed *(Month, Day, Year)*: November 24th 1999
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): AL JAWAD WAQAS, 11119 ROCKVILLE PIKE SUITE 100 ROCKVILLE MD 20852

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 30 1999
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39656

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret B. Kerwin
2. Date of Death Month Day Year: December 1, 1999
3. Time of Death: 7:45 pm
4a. Facility Name *(If not institution, give street and number)*: Montgomery Village Care & Rehabilitation
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 121-26-0486
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 65 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan 6, 1934
9. Birthplace *(State or Foreign Country)*: New York

Usual Residance of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5901 Montrose Road
10f. Zip Code: 20852
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Insurance Representative
16b. Kind of Business/Industry: Insurance

17. Father's Name *(First, Middle, Last)*: Thomas Doolan
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Gerrity

19a. Informant's Name/Relationship *(Type, Print)*: Michael P. Kerwin/ Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5901 Montrose Road, Rockville, MD 20852

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory
Date: 12/6/99
20c. Location - City or Town, State: Alexandria , VA

21. Signature of Funeral Service Licensee: Scott L. Smith
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	2 weeks
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. multiple Sclerosis	years
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.
29c. License number: D44157
29d. Data signed *(Month, Day, Year)*: December 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ira Berger M.D. 809 Vetrs Mill Road, Rockville, Maryland 20851

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 03 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

99-7100-027
KIMBERLY E. KNOTTS
ASP amend item 27 per me G788 10/10/00 yf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39657

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KIMBERLY ELIZABETH KNOTTS
2. Date of Death: Month NOVEMBER Day 27 Year 1999
3. Time of Death: 9:35 P
4e. Facility Name (If not institution, give street and number): ROUTE# 108 & WEST RED BRANCH RD.
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 220-13-8726
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 22 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB. 18, 1977
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: HOWARD
10c. City, Town or Location: COLUMBIA
10d. Inside City Limits: ☒ Yes 2☐ No
10e. Street and Number: 6408 SEWELLS ORCHARD DRIVE
10f. Zip Code: 21045
10g. Citizen of What Country?: UNITED STATES
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): STUDENT
16b. Kind of Business/Industry: SCHOOL
17. Father's Name (First, Middle, Last): JOHN FREDERICK KNOTTS
18. Mother's Name (First, Middle, Maiden Surname): NANCY ELIZABETH WOLFF
19e. Informant's Name/Relationship (Type, Print): NANCY E. KNOTTS - MOTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6408 SEWELLS ORCHARD DRIVE, COLUMBIA, MD 21045
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): FT. LINCOLN CREMATORY
Date: 11-29-99
20c. Location - City or Town, State: BRENTWOOD, MARYLAND
21. Signature of Funeral Service Licensee: James D. Schultz
22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE., SILVER SPRING, MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Head Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Home 5☐ Residence ☒ Other (Specify) SCENE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): 11-27-99
28b. Time of Injury: 9:25 PM
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: occupant auto - fixed object collision
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): roadway
28f. Location (Street and Number or Rural Route Number, City or Town, State): RT 108

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: O.C.M.E
29c. License number
29d. Date signed (Month, Day, Year): NOVEMBER 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999
32. Registrar's Signature: Jeanne B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39658

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LOUIS G. KRAKOWER

2. Date of Death: Month: Dec; Day: 1st; Year: 1999

3. Time of Death: 9:10 pm

4a. Facility Name (If not institution, give street and number): HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 550.14.2137

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 04.23.1907

9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: MD

10b. County: MONTGOMERY

10c. City, Town or Location: ROCKVILLE

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 6121 MONTROSE ROAD

10f. Zip Code: 20852

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): OWNER

16b. Kind of Business/Industry: MEN'S TAILOR

17. Father's Name (First, Middle, Last): JACK KRAKOWER

18. Mother's Name (First, Middle, Maiden Surname): REGINA MOSKOWITZ

19a. Informant's Name/Relationship (Type, Print): JACK KRAKOWER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7441 MAHASKA DRIVE, DERWOOD, MARYLAND 20855

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): HILLSIDE MEMORIAL PARK

Date: 12.05.99

20c. Location - City or Town, State: LOS ANGELES, CA

21. Signeture of Funerel Service Licensee: [signature]

22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)

a. acute cardio-pulmonary arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

b. hepatic obstruction

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cerebral Ischemia Glaucoma

Congestive heart failure

Coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☐ **Certifying Phyalcian:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es steted. 2 ☐ **Medicat Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Consult Manager

29c. License number: D:44907

29d. Date signed (Month, Day, Year): Dec 2nd 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CONSUELO ALVAREZ, MD 6121 Montrose Road, Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Yeer): DEC 03 1999

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Krakower, Louis

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39659

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Theresa C. Laniado

2. Data of Death — Month: November Day: 29 Year: 1999

3. Tima of Daath: 2:30 AM

4e. Facility Name (If not institution, give street end number): Gilchrist Center for Hospice Care

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 150 12 5035

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Data of Birth (Month, Day, Yaar): April 9,1926

9. Birthplace (Stete or Foreign Country): New Jersey

To Be Completed by Funeral Director

Usual Rasidance of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 5400 Vantage Point Rd. Apt. G2

10f. Zip Code: 21044

10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowad 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Amarican Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grada completed)

Elementary/Sacondary (0-12): 11

College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middla, Last): Giuseppe Ubaldo

18. Mother's Name (First, Middle, Maidan Surneme): Emma Domiano

19a. Informant's Name/Relationship (Type, Print): George Lanioado/ Husband

19b. Mailing Address (Straat and Number or Rurel Routa Number, City or Town, Stete, Zip Coda): 5400 Vantage Point Road Columbia, MD 21044

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cametery, cremetory or other place): Chesapeake Crematory,Inc.

Date: 11/30/99

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funerel Sarvice Licensee: Carol A Dohrmann

22. Name and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Drive Baltimore,MD 21286

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Entar tha diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haart failura. List only ona causa on aach lina.

Approximate Intarval Batwaan Onsat and Death

Immediate Causa (Final disaasa or condition resulting in daath)

a. Colon cancer — 4 years

Due to (or as a consequence of):

Sequantially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or injury that initiated avants resulting in daath) Lest

b.

Due to (or as e consaquence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other aignificent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the ceuse of deeth? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case refarred to medical axaminar? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Mannar of Daath: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending Invastigation 6☐ Could not be datermined

28a. Data of Injury (Month, Dey Yeer):

28b. Time of injury: M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascriba how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Spacity):

28f. Location (Street and Number or Rurel Route Number, City or Town, Steta)

29a. Certifiar (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, date and piece, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier: N Anthony Riley, MD

29c. License number: D25205

29d. Date signed (Month, Dey, Yaar): November 29, 1999

30. Nama and address of parson who completed cause of death (Item 23a) (Type, Print): W. A. Riley GP/MC 6701 N. Charles St. Balto. md 21204

State Registrar

31. Data filed (Month, Day, Year): DEC 0 1 1999

32. Registrar's Signature: Steven D. Lohr

DHMH 16 Rev 6/95

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Laniado, Theresa

SR 11-29-99 2:30AM

6

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39660

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Violet Lewis
2. Date of Death: Month 11 Day 29 Year 99
3. Time of Death: 8:10 AM
4a. Facility Name (If not institution, give street and number): 102 Crain Hwy. Apt. #940
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 285 07 7494
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 15, 1904
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 102 Crain Hwy., Apt. 940
10f. Zip Code: 21061
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress
16b. Kind of Business/Industry: Textile

17. Father's Name (First, Middle, Last): George A. Hocker
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Miller

19a. Informant's Neme/Relationship (Type, Print): Sharon H. Sturch / Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1312 Pleasant Valley Dr., Baltimore, MD 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Shoop's Cemetery | Dete: 12/2/99
20c. Location - City or Town, Stete: Harrisburg, PA

21. Signature of Funeral Service Licensee: Stephen D Lohrmann
22. Name and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth): a. Atherosclerotic heart disease

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other signifiicant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Aortic Stenosis

23b. Did tobacco use contribute to tha cauaa of death? 1☐ Yaa 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete end place, and due to the ceuse(s) and manner es stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Peter P Rumsys
29c. License number: 047137
29d. Date signed (Month, Day, Year): November, 30, 1999

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): 7847 Oakwood rd Glen Burnie, Maryland 21061

State Registrar

31. Dete filed (Month, Day, Year): DEC 03 1999
32. Registrar's Signature: Barbara B. Lane

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

(5)

DEC 0 3 1988

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39661

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Manson Ligon

2. Date of Death: Month 10 Day 24 Year 99

3. Time of Death: 11:24 PM

4a. Facility Name (If not institution, give street and number): Prince George's Hospital Center

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-12-9367

6. Sex: 1 XX M 2 ☐ F

7. Age (In yrs, last birthday): 100 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 5, 1899

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: D.C.

10b. County:

10c. City, Town or Location: Washington

10d. Inside City Limits: 1 XX Yes 2 ☐ No

10e. Street and Number: 236 Division Avenue, N.E.

10f. Zip Code: 20019

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XX No Specify:

14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 7th grade
College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist

16b. Kind of Business/Industry: Navy Yard (Retired)

17. Fether's Neme (First, Middle, Last): Robert Ligon

18. Mother's Name (First, Middle, Maiden Sumeme): Elizabeth Jiles

19a. Informant's Name/Relationship (Type, Print): Mrs. Mary J. Richardson (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 10123 Campus Way SOuth Largo, Maryland 20774

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Lincoln Memorial Cemetery

Date: 10/29/99

20c. Location - City or Town, State: Landover, Maryaldn

21. Signature of Funeral Service licensee: Janet C. Anderson

22. Name and Address of Facility: Rollins FUneral HOme, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or conditlon resulting in death): a. Pulmonary Embolus

Due to (or as a consequence of): b. Deep Vein Thrombosis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Lest

Due to (or as a consequence of): c. Hip Surgery

Due to (or as a consequence of): d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 XX Yes 2 ☐ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 XX ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☐ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Casey Jason

29c. License number: D34526

29d. Dete signed (Month, Dey, Yeer): 10.24.99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Casey Jason, MD 5268 Dawes Avenue Alexandria, Virginia 22311

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999

32. Registrar's Signature: Barbara D. Goode

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DEC 0 3 1883

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39662

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ronald James Lewis

2. Date of Death (Month, Day, Year): November 27, 1999

3. Time of Death: 1208 PM

4a. Facility Name (If not institution, give street and number): Stella Maris Hospice at Mercy Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 220-86-4623

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 37 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 22, 1962

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4301 Ridgewood Avenue

10f. Zip Code: 21215

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodian

16b. Kind of Business/Industry: University of Maryland Hospital

17. Father's Name (First, Middle, Last): Unknown

18. Mother's Name (First, Middle, Maiden Surname): Edna Taylor

19a. Informant's Name/Relationship (Type, Print): Michael C. Lewis/ Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3900 North Charles St. Apt. 601 Baltimore, MD 21218

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory, Inc

Date: 11/30/99

20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Laura C. Hardesty

22. Name and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Drive Baltimore, MD 21286

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. AIDS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David Rusyberg MD

29c. License number: D40854

29d. Date signed (Month, Day, Year): 11/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Rusyberg 301 St Paul Pl Baltimore 21202

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999

32. Registrar's Signature: Stephen D. Lohrmann

DHMH 16 Rev 6/95

ORIGINAL

NOV 3 0 1993

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39663

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marie S. Lewis
2. Date of Death (Month, Day, Year): Nov. 28 99
3. Time of Death: 0814
4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 419-12-7585
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 24, 1922
9. Birthplace (State or Foreign Country): Alabama

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Waldorf
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3373 Justice Court
10f. Zip Code: 20602-2505
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Clarence William Smith
18. Mother's Name (First, Middle, Maiden Surname): Helen Montgomery

19a. Informant's Name/Relationship (Type, Print): Steve Lewis (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3373 Justice Court Waldorf, Maryland 20602-2505

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lee Crematory
Date: Nov. 30, 1999
20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: S. Smith
22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — 4 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? N/A 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D-18545
29d. Date signed (Month, Day, Year): NOVEMBER 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): P. WISOFSKY M.D. 12070 OLD LINE CENTER WALDORF, Md. 20602

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39664

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Arlene S. Lewis

2. Date of Death Month / Day / Year: Nov. 23 1999

3. Time of Death: 2:53 AM

4a. Facility Name *(If not Institution, give street and number)*: 12500 Rustic Hill Drive

4b. City, Town, or Location of Death: Bowie

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 215 24 1044

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 25 1929

9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Bowie

10d. Inside City Limits: ☒ Yes 2☐ No

10e. Street and Number: 12500 Rustic Hill Drive

10f. Zip Code: 20715

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married ☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nurse

16b. Kind of Business/Industry: Health Care

17. Father's Name *(First, Middle, Last)*: Paul Shaffer

18. Mother's Name *(First, Middle, Maiden Surname)*: Pearl Darrington

19a. Informant's Name/Relationship *(Type, Print)*: Stacie Lewis Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12500 Rustic Hill Drive Bowie Maryland 20715

20a. Method of Disposition: ☒ 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lakemont Memorial Gardens Date: Nov. 27, 1999

20c. Location - City or Town, State: Davidsonville Maryland

21. Signature of Funeral Service Licensee: ▶ Jamart Govon

22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic obstructive pulmonary disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Interstitial pulmonary fibrosis

Coronary artery disease

23b. Did tobacco use contribute to the cause of death? ☒ 1 Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes ☒ 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes ☒ 2 No

25. Was case referred to medical examiner? 1☐ Yes ☒ 2 No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home ☒ 5 Residence 8☐ Other *(Specify)*

27. Manner of Death: ☒ 1 Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: ☒ 1 **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶

29c. License number: D55187

29d. Date signed *(Month, Day, Year)*: 11/23/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 64 Franklin Street, Annapolis, MD 21401

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 29 1999

32. Registrar's Signature

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

NOV 2 3 1999

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39665

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EDWARD ARTHUR LIGHTFOOT

2. Date of Death Month Dey Year: November 19,1999

3. Time of Death: 8:30 PM

4a Facility Neme *(If not institution, give street end number)*: 6827 GROVETON Drive

4b. City, Town, or Location of Death: Clinton

4c. County of Deeth: Prince Georges'

Funeral Director

5. Social Security Number: 578-07-3760

6. Sex: 1☐ M 2☐ F — X

7. Age *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 24,1910

9. Birthplace *(State or Foreign Country)*: Big Island,Va.

Usuel Residenca of Decedent

10a. State

10b. County

10c. City, Town or Location: Washington,D.C.

10d. Insida City Limits: X 1☐ Yes 2☐ No

10e. Streat and Number: 335 Webster Street, N.W.

10f. Zip Code: 20011

10g. Citizen of Whet Country?: U.S.A.

11. Marital Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced — X

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No — X
If Yes, Give Year or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1☐ Yes 2☒ No — XX
Specify:

14. Race - American Indien, Black, White, etc.
Specify: Black

15. Decedent's Education *(Specify only highest grede completed)*
Elementary/Secondary (0-12): 8th
College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Building Engineer

16b. Kind of Business/Industry: Woodward Building

17. Father's Neme *(First, Middle, Last)*: William Henry Lightfoot

18. Mother's Name *(First, Middle, Maiden Sumame)*: Flora Moore

19a. Informant's Neme/Relationship *(Type, Print)*: Eddye Jean Morris/daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6827 Groveton Drive Clinton,Md. 20735

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)* — X

20b. Pleca of Disposition *(Neme of cemetery, crematory or other piece)*: Fort Lincoln Cemetery

Dete: 11/24/99

20c. Location - City or Town, State: Brentwood, Maryland

21. Signatura of Funeral Service Licensee: W. D. Jeffers

22. Name and Address of Facility: Frazier's Funeral Home, Inc.
389 Rhode Island Ave., N.W. Wash.,DC 20001

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Intervel Between Onset end Death

Immediate Cause (Finel disease or condition resulting in deeth)
e. Emphysema

Due to (or es e consequence of):
b. Heart Failure

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest
Due to (or as a consequence of):
c.

Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Myocardial Infarction (162)
Peripheral Vascular Disease
Arthritis

23b. Did tobacco use contribute to the cause of death?
1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown — X

24a. Wes en autopsy performed?
1☐ Yes 2☒ No — X

24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No

25. Was case referred to medical examiner?
1☐ Yes 2☒ No — X

26. Place of Deeth *(Check only one)*
Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residenca 6☒ Other *(Specify)* — X Daughter's Residence

27. Manner of Death
1☒ Neturel — X
2☐ Accident
3☐ Suicide
4☐ Homicide
5☐ Pending investigation
6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*
1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner es steted. — X
2☐ **Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: Rene Grace Physician

29c. License number: DO2259

29d. Date signed *(Month, Day, Year)*: Nov 29 99

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print): Rene Grace, MD 9131 Piscatway Road Suite 260 Clinton, Maryland 20735

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

(12)

State Registrar

31. Dete filed *(Month, Day, Year)*: NOV 29 1999

32. Registrer's Signeture: Barbara B. Goertz

DHMH 16 Rev 6/95

ORIGINAL

NOV 2 9 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39666

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Antoinette LaFontaine

2. Date of Death (Month, Day, Year): November 19, 1999

3. Time of Death: 11:40 pm

4a. Facility Name (If not institution, give street and number): Sacred Heart Nursing Home

4b. City, Town, or Location of Death: Hyattsville

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 029-01-7953

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 1, 1907

9. Birthplace (State or Foreign Country): Canada

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5805 Queens Chapel Road

10f. Zip Code: 20782

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Aime Bourdeau

18. Mother's Name (First, Middle, Maiden Surname): Celina La Casse

19a. Informant's Name/Relationship (Type, Print): Jeannine Fisher - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3305 Calle Quervo, Albuquerque, NM 87114

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bellevue Cemetery | Date: 11/26/99

20c. Location - City or Town, State: Adams, Massachusetts

21. Signature of Funeral Service Licensee: ▶ Claudette L. Gasch

22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ASPIRATION PNEUMONIA — 24 HRS

Due to (or as a consequence of):
b. SENILE DEMENTIA — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Peter M. Schissler

29c. License number: D22780

29d. Date signed (Month, Day, Year): November 22, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter M. Schissler, M.D. 7500 Greenway Center Drive #430, Greenbelt, MD 20770-3542

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999

32. Registrar's Signature: Barbara G. Frank

DHMH 16 Rev 6/95

ORIGINAL

NOV 2 9 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39667

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BLANCHE LANE
2. Date of Death: Month NOV Day 20 Year 99
3. Time of Death: 4:30A
4a. Facility Name (If not institution, give street and number): CRESCENT CITIES CENTER
4b. City, Town, or Location of Death: RIVERDALE
4c. County of Death: P.G. MD

Funeral Director

5. Social Security Number: 579-50-9504
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3-10-12
9. Birthplace (State or Foreign Country): West Indies

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6617 24th Avenue
10f. Zip Code: 20782
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2yrs.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Licensed Practical Nurse
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Robert McDermott
18. Mother's Name (First, Middle, Maiden Surname): Lucy White

19a. Informant's Name/Relationship (Type, Print): Lema Crooks/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2717 Bellbrook Street, Temple Hills, Maryland 20748

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery
Date: 11/27 1999
20c. Location - City or Town, State: Suitland, Maryland

21. Signature of Funeral Service Licensee: Belva J. Jenkins
22. Name and Address of Facility: J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart teilure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): CARCINOMA COLON WITH METASTASES — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last

b. Due to (or as e consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PARKINSON'S Disease

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: [signature]
29c. License number: D01852
29d. Date signed (Month, Day, Year): NOVEMBER 23 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL A. DEVORE MD 4203 QUEENSBURY Rd HYATTSVILLE MD 20781

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999
32. Registrar's Signature: [signature] B. [illegible]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NOV 2 9 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39668

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary A. Latham
2. Date of Death (Month, Day, Year): December 3, 1999
3. Time of Death: 10:45 P.M.
4a. Facility Name (If not institution, give street and number): Lorien Nursing Home
4b. City, Town, or Location of Death: Belcamp
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 216-10-9536
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sep. 17, 1919
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Edgewood
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1203 Chipper Drive
10f. Zip Code: 21040
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: In home

17. Father's Name (First, Middle, Last): Hugh Fox
18. Mother's Name (First, Middle, Maiden Surname): Catherine Flynn

19a. Informant's Name/Relationship (Type, Print): Walter Latham (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1203 Chipper Drive, Edgewood, Maryland 21040

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): R. A. Ferris & Co., Inc.
Date: 12/7/99
20c. Location - City or Town, State: West Chester, PA

21. Signature of Funeral Service Licensee: Kirsten Arrington-Lesbee
22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Brain cancer
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: David McClure MD
29c. License number: D27925
29d. Date signed (Month, Day, Year): 12/8/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David McClure MD 615 Marshall Rd Bel Air, MD 21014

State Registrar

31. Date filed (Month, Day, Year): DEC 06 1999
32. Registrar's Signature: B. Spark

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Amended
Line 8. WCHD/SC
12-3-99

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 99 39669

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ronald Hetrick Lucas
2. Date of Death (Month, Day, Year): November 30, 1999
3. Time of Death: 10:20
4e. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 215-26-1824
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 67 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): ~~March~~ March 12, 1932
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1204 Wabash Avenue
10f. Zip Code: 21740
10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes: 48-52
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): machinists
16b. Kind of Business/Industry: Mack Trucks, Inc.

17. Father's Neme (First, Middle, Last): Lewis Lucas
18. Mother's Neme (First, Middle, Maiden Surneme): Genieve Brandt

19e. Informent's Name/Reletionship (Type, Print): Carolyn A. Lucas Wife
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 1204 Wabash Avenue Hagerstown, Maryland 21740

20e. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory
Dete: 12/3/99
20c. Location - City or Town, Stete: Smithsburg Maryland

21. Signature of Funeral Service Licensee: Gerald N. Minnich
22. Name and Address of Feclity: Gerald N. Minnich Funeral Home, 305 N. Potomac Street Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert tailure. List only one ceuse on eech line.

Approximete Intervel Between Onset and Death

Immediete Cause (Finel disease or condition resulting in deeth):
a. Arteriosclerotic Heart Disease
Due to (or es e consequence of):
b. Diabetic ischemic cardiomyopathy — 4 yrs

Sequentially list conditions, If any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Last
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medicat examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one)
Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated.
2☐ **Medicat Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end pleca, and due to the ceuse(s) end menner steted.

29b. Signature and title of certifier: John Hornbaker MD
29c. License number: D07885
29d. Date signed (Month, Dey, Year): 12-1-99

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print): Dr. Hornbaker 11110 Medical Campus Rd Hag. Md

State Registrar

31. Dete filed (Month, Day, Year):
32. Registrer's Signeture:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Lucas, Ronald

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39670

Sarah V. Lehman

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SARAH V. LEHMAN
2. Date of Death: Month Nov. Day 27 Year 1999
3. Time of Death: 2:15 PM
4a. Facility Name (If not Institution, give street and number): Fahrney-Keedy Nursing Home
4b. City, Town, or Location of Death: Boonsboro
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 217-09-9880
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 28, 1917
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Boonsboro
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8507 Mapleville Road
10f. Zip Code: 21713-1844
10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John E. Boyer
18. Mother's Name (First, Middle, Maiden Surname): Pamela M. Dunlap

19a. Informant's Name/Relationship (Type, Print): Fred M. Lehman-Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 217 Euclid Avenue, Charles Town, WV 25414

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Omps Crematory
Date: 11/28/99
20c. Location - City or Town, State: Winchester, VA

21. Signature of Funeral Service Licensee: Joan S. Christian
22. Name and Address of Facility: Melvin T. Strider Colonial Funeral Home, P.O. Box 388, Charles Town, WV 25414

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	METABOLIC ENCEPHLOPATHY	ONE WK
Due to (or as a consequence of): b.	DEHYDRATION	TWO WKS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.	ALZHEIMER'S DEMENTIA	YEARS
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ATHROSCLEROSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): ☒ 1 **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ 2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D44996
29d. Date signed (Month, Day, Year): NOV 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ZAFAR MALIK MD 20311 LAPPANS RD BOONSBORO, MD 21713

State Registrar

31. Data filed (Month, Day, Year): NOV 30 1999
32. Registrar's Signature: B. Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician**: The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39671

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Frank Joseph LEN
2. Data of Death Month Day Year: NOVEMBER 24, 1999
3. Time of Death: 3:30 PM
4a. Facility Name *(If not institution, give street and number)*: RAVENWOOD LUTHERAN VILLAGE
4b. City, Town, or Location of Death: HAGERSTOWN
4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 209-10-9935
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: March 26 1917
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒Yes 2☐No
10a. Street and Number: 934 Noland Drive
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: W.W. II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Steelworker - Machinist
16b. Kind of Business/Industry: Truck Manufacturer
17. Father's Name *(First, Middle, Last)*: Joseph Len
18. Mother's Name *(First, Middle, Maiden Sumama)*: Katherine Kostka
19a. Informant's Name/Relationship *(Type, Print)*: Rose H. Len - Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 934 Noland Drive Hagerstown, Maryland 21740
20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rest Haven Cemetery
Data: 11/29/99
20c. Location - City or Town, State: Hagerstown, Maryland
21. Signature of Funeral Service Licensee: Scott Minnich
22. Name and Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS — 1 week
Due to (or as a consequence of):
b. Foot Infection, Pneumonia
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Renal Failure; Stroke; Hypertension.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☑Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Eli Rozo MD
29c. License number: D-22313
29d. Data signed *(Month, Day, Year)*: 11-24-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ELI ROZO MD 12731 OAK HILL AVE HAGERSTOWN, MD 21742

State Registrar

31. Data filed *(Month, Day, Year)*: NOV 29 1999
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

LEN, Frank Joseph

ORIGINAL

WRC
99-7207-017
RUSSELL
LYLES AMEND#23&27-28f PER M.E.O. G778 12-20-99 J.A

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39672

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Russell Leon Lyles Jr.

2. Date of Death (Month, Day, Year): DECEMBER 01, 1999

3. Time of Death: 4:10 PM.

4e. Facility Name (If not institution, give street and number): CIVISTA MEDICAL CENTER

4b. City, Town, or Location of Death: LA PLATA

4c. County of Death: Charles

Funeral Director

5. Social Security Number: 217-06-1331

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 15 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 9,1984

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Charles

10c. City, Town or Location: Hughesville

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 16420 Overhill Way

10f. Zip Code: 20637

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student

16b. Kind of Business/Industry: Thomas Stone High

17. Father's Name (First, Middle, Last): Russell Leon Lyles Sr.

18. Mother's Name (First, Middle, Maiden Surname): Patricia D. Chase

19e. Informant's Name/Relationship (Type, Print): Patricia Chase- Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16420 Overhill Way Hughesville,Maryland 20637

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Trinity Mem. Gardens

Date: 12/7/99

20c. Location - City or Town, State: Waldorf,Maryland

21. Signature of Funeral Service Licensee: Lloyd M Estep M00191

22. Name and Address of Facility: Adams Funeral Home P.A. Aquasco,Maryland 20608

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. POSITIONAL ASPHYXIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): 12-1-99

28b. Time of Injury: UNKNOWN M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: SUBJECT'S FACE PINNED BETWEEN WHEELCHAIR OPERATING ROD AND BLEACHERS

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): BUILDING

28f. Location (Street and Number or Rural Route Number, City or Town, State): THOMAS STONE HIGH SCHOOL CHARLES CO., MD.

29e. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): DECEMBER 02, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Clifton Locke, MD 111 Penn Street, Baltimore, Maryland 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): DEC 06 1999

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39673

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert Joseph Lessard

2. Data of Death — Month: November Day: 29 Year: 1999

3. Time of Death: 3:00 p.m.

4a. Facility Name *(If not institution, give street and number)*: Fallston General Hospital

4b. City, Town, or Location of Death: Fallston

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 477-12-0933

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year — Months: Days: If Under 24 Hrs. — Hours: Min.:

8. Data of Birth *(Month, Day, Year)*: Mar. 11, 1923

9. Birthplace *(State or Foreign Country)*: Minnesota

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Abingdon

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 508 Apt. 3 Eastview Terr.

10f. Zip Code: 21009

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: Korean WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Military

16b. Kind of Business/Industry: U.S. Government

17. Father's Name *(First, Middle, Last)*: Louis L. Lessard

18. Mother's Name *(First, Middle, Maiden Surname)*: Emma M. Sampson

19a. Informant's Name/Relationship *(Type, Print)*: Denise Fowler / Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 608 Apt. C Riley Ct., Joppatowne, Maryland 21085

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Arlington National Cem.

Data: 12-8-99

20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: Steven A. Mench

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — 4 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PERIPHERAL VASCULAR DISEASE

CEREBROVASCULAR ACCIDENT

CHRONIC RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: V Abhyankar MD

29c. License number: D25027

29d. Data signed *(Month, Day, Year)*: NOVEMBER 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VIJAY M. ABHYANKAR 2 NORTH AVENUE BEL AIR MD 21014

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 02 1999

32. Registrar's Signature: Denise G. Sparks

DHMH 16 Rev 6/95

Lessard, Robert Joseph SR

10+1

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39674

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BEULAH MAE LAPPIN
2. Date of Death (Month, Day, Year): NOVEMBER 28, 1999
3. Time of Death: 7:47 PM
4a. Facility Name (If not institution, give street and number): FRIENDS NURSING HOME
4b. City, Town, or Location of Death: SANDY SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 579-46-5006
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 10, 1909
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 15101 Interlachen Drive
10f. Zip Code: 20906
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Engelhaupt
18. Mother's Name (First, Middle, Maiden Surname): Carrie Calloway

19a. Informant's Name/Relationship (Type, Print): John E. Lappin / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 204 West Hanover Place, Sterling, Virginia 20164

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): George Washington Cem. | Date: 12/3/99
20c. Location - City or Town, State: Adelphi, Maryland

21. Signature of Funeral Service Licensee: ▶ Muriel H. Barber
22. Name and Address of Facility: Muriel H. Barber Funeral Home, P. O. Box 5038, Laytonsville, Maryland 20882

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. LUNG CARCINOMA	6 MONTHS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Abeda Ali Khan M.D.
29c. License number: D43323
29d. Date signed (Month, Day, Year): NOVEMBER 29,1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ABEDA ALI KHAN, 10794 HICKORY RIDGE ROAD COLUMBIA MD 21044

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39675

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
JEANNETTE OWEN LEWIS	NOV 28 1999	5:11 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NATIONAL NAVAL MEDICAL CENTER	BETHESDA	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-12-7752	1☐ M 2☒ F	77 Yrs.			October 13, 1922	Washington, D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Potomac	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
12334 Old Canal Road	20854	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Banks Owen	Dorothy Lietzel

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Robert T. Lewis/Son	9937 Dellcastle Road, Montgomery Village, MD 20886

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Arlington National Cemetery	Dec. 8, 1999	Arlington, Virginia

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ MO1126	Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

b

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CONGESTIVE HEART FAILURE	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. aortic stenosis	
	Due to (or as a consequence of):	
	c. acute renal failure	
	Due to (or as a consequence of):	
	d. myocardial infarction	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ DE Allen MD	16000 (MS)	11/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
DAVID E. ALLEN, LT, MC, USN	NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 01 1999	▶ Geneva G. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39676

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lawrence Lomax

2. Data of Death: Month NOVEMBER Day 23 Year 1999

3. Time of Death: 12:05 p.m.

4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 228-62-9134

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 53 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): May 21 1946

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedant

10a. State: D.C.

10b. County:

10c. City, Town or Location: Washington, D.C.

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1957 Biltmore St. N.W.

10f. Zip Code: 20009

10g. Citizen of What Country?: U.S.A.

11. Maritel Stetus: 1☒ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Evar in U.S. Armed Forcas? 1☒ Yes 2☐ No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Antique Dealer

16b. Kind of Business/Industry: Antique Owner

17. Father's Nema (First, Middle, Last): Ralph Easton Lomax Sr.

18. Mother's Name (First, Middle, Maidan Surname): Grace Dailey Wheatfield

19a. Informant's Name/Ralationship (Type, Print): Patrick Dolan

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 1957 Biltmore St. N.W. Washington, D.C. 20009

20a. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Name of cematary, crematory or other place): National Crematory

Date: 12/3/99

20c. Location - City or Town, Stata: Falls Church, VA.

21. Signatura of Funaral Sarvice Licensee ▶ [signature]

22. Nama and Address of Facility: Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. N.W. Washington, D.C. 20016

Physician /Medical Examiner

23a. Part1. Entar the diseasa, or complications thet caused tha death. Do not entar the mode of dying, such as cardiac or raspiratory errest, shock, or heart failure. List only ona cause on aach lina.

Approximata Intarval Batwaen Onset and Death

Immediate Causa (Final disaase or condition rasulting in daath)
a. Brain Tumor — two years

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated evants resulting in daath) Last
b.

Dua to (or as a consequence of):
c.

Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yas 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was casa referrad to medical examinar? 1☐ Yas 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to tha cause(s) and mannar stated.

29b. Signatura and title of certifiar: ▶ Amer Samdani

29c. License number: Res-000

29d. Data signed (Month, Day, Year): November 23, 1999

30. Nama and addrass of person who complatad causa of death (Item 23a) (Type, Print): Amer Samdani, Johns Hopkins Hospital

State Registrar

31. Date filed (Month, Day, Year): NOV 26 1999

32. Registrar's Signature: ▶ [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39677

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Maria E. Lopez

2. Date of Death (Month, Day, Year): November 29, 1999

3. Time of Death: 9:15 pm

4a. Facility Name (If not institution, give street and number): Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 125-44-7743

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 5, 1923

9. Birthplace (State or Foreign Country): Dominican Rep.

Usual Residence of Decedent

10a. State: New York

10b. County: New York

10c. City, Town or Location: East Elmhurst

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 24-37 96th Street

10f. Zip Code: 11369

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☒ Yes 2☐ No Specify: Dominican

14. Race - American Indien, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 2

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired): Secretary

16b. Kind of Business/Industry: Clerical

17. Father's Name (First, Middle, Last): Ramon Josa

18. Mother's Neme (First, Middle, Maiden Surneme): Everides Navarro

19a. Informent's Name/Reletionship (Type, Print): Luisa Lopez-Gaffney/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 902 Twinbrook Pkwy, Rockville, MD 20851

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removet from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, crematory or other place): Gate of Heaven Cemetery

Dete: 12/2/99

20c. Location - City or Town, Stete: Silver Spring, MD

21. Signature of Funeral Service Licensee: Eric S. Scerbo

22. Name end Address of Fecility: Francis J. Collins Funeral Home, Inc. 500 University Blvd,W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failurb. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Finet disease or condition resulting in death)
a. METASTATIC BREAST CANCER — 5 YRS

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
b.

Due to (or es a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings avellable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturat 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end manner es steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or Investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner stated.

29b. Signeture and title of certifier: Carolyn B Hendricks MD

29c. License number: D37236

29d. Date signed (Month, Day, Year): NOVEMBER 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CAROLYN B. HENDRICKS MD 6410 ROCKLEDGE DR #305 BETHESDA MD 20814

State Registrar

31. Date filed (Month, Day, Year): DEC 02 1999

32. Registrar's Signeture: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Lopez, Maria 11-29-99 915

Lopez, Maria 11/29/99 915 pm

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39678

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert McLeod

2. Date of Death: Month 12 Day 1 Year 99

3. Time of Death: 4;20PM

4a. Facility Name (If not institution, give street and number): HOLLY CROSS HOSPITAL

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-62-8540

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 54 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11-6-45

9. Birthplace (State or Foreign Country): D.C.

Usual Residence of Decedent

10a. State: MD

10b. County: MONTGOMERY

10c. City, Town or Location: SILVER SPRING

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10a. Street and Number: 9110 WALDEN RD.

10f. Zip Code: 20901

10g. Citizen of What Country?: u.s.a.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MAIL HANDLER

16b. Kind of Business/Industry: U.S.POST OFFICE

17. Father's Name (First, Middle, Last): NORMAN McLEOD

18. Mother's Name (First, Middle, Maiden Surname): SYDNEY SMITH

19a. Informant's Name/Relationship (Type, Print): BEVERLY J.MCLEOD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9110 WALDEN RD. SILVER SPRING,MD.

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): CHAMBERS, CREMATORY | Date: 12/7/99

20c. Location - City or Town, State: RIVERDALE,MD

21. Signature of Funeral Service Licensee: James E. Williams

22. Name and Address of Facility: THE HOUSE OF WILLIAMS 5732 GEORGIA AVE.N.W.WASHINGTON,D.C.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Septic shock

Due to (or as a consequence of):
b. Metastic Cancer to Bone. Liver. abdomen

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Primary site unknown

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mhoo Pang

29c. License number: D0055213

29d. Data signed (Month, Day, Year): 12-2-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Y.S.PANG Holly Cross Hosp. 1500 Forest Glen. S. Spring MD

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999

32. Registrar's Signature:

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

ORIGINAL

DEC 03 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39679

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert N. Miller
2. Dete of Deeth: Month 11 / Day 27 / Year 1999
3. Time of Deeth: 0630
4e. Feciity Neme (If not institution, give street end number): Bayside Nursing Center
4b. City, Town, or Location of Deeth: Lexington Park
4c. County of Deeth: St. Mary's

Funeral Director

5. Social Security Number: 579-14-1886
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. lest birthday): 81 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): June 24, 1918
9. Birthplace (State or Foraign Country): Pennsylvania

Usuel Residence of Decedent

10e. Steta: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Lexington Park
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 21606 Forest Park Road
10f. Zip Code: 20653
10g. Citizen of Whet Country?: U.S.A.

11. Maritel Stetus: 1 [ ] Never Marriad 2 [XX] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Giva Yeer or Dates: 1942-46
13. Was Decedant of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Rece - Americen Indien, Bleck, White, etc. Specify: white
15. Decedent's Eddcetion (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | Collega (1-4or 5+):
16a. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa ratired): Elevator Inspector
16b. Kind of Business/Industry: US Government
17. Fether's Name (First, Middle, Last): Stuart Miller
18. Mother's Name (First, Middle, Meiden Surname): Mary Rich
19e. Informent's Name/Reletionship (Type, Print): Violet M. Miller/Wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 21606 Forest Park Rd. Lexington Park, MD 20653
20e. Method of Disposition: 1 [XX] Buriel 2 [ ] Cremetion 3 [ ] Removal from Stete 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Ft. Lincoln Cemetery
Date: Nov. 29, 1999
20c. Location - City or Town, Stete: Brentwood, MD
21. Signature of Funeral Service Licensee: Daya Y Mellark
22. Neme end Address of Facility: Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that ceusad the deeth. Do not enter the moda of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one ceusa on aach line.

Approximete Intervel Batwaan Onset end Death

Immedieta Cause (Finel disease or condition resulting in daath): e. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE — YRS

Dua to (or es e consaquance of):

Sequentiellу list conditions, if eny, leeding to immediate cause. Enter Underlying Ceusa (Disease or Injury thet initieted events resulting in deeth) Lest:

b. Dua to (or es e consequence of):

c. Dua to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PARKINSON'S DISEASE

CVA

DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24e. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Wara autopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes cesa referred to medicel examiner? 1 [ ] Yes 2 [X] No

26. Piece of Daeth (Check only ona): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Sulcide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determinad

28e. Deta of Injury (Month, Dey Yeer):
28b. Time of Injury:
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 [X] **Certifying Phyeician:** To the best of my knowledga, death occurred at the time, dete end piece, end dua to tha cause(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, deta end place, end due to the ceusa(s) end menner steted.

29b. Signature and title of certifier: M Boyd MD
29c. License number: D14285
29d. Date signed (Month, Dey, Yeer): 11-27-99.

30. Nema and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): Dr. William Boyd, 25365 Point Lookout Road Leonard Town, 20650

State Registrar

31. Date filed (Month, Dey, Yeer): NOV 30 1999
32. Registrer's Signature: Barbara B. Frank

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Robert Miller

20

NOV 3 0 1993

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39680

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY B. MAGGIO
2. Date of Death (Month, Day, Year): NOVEMBER 26, 1999
3. Time of Death: 7:00 AM
4a. Facility Name (If not institution, give street and number): 35 MILKSHAKE LANE/SKILLED NURSING HOME
4b. City, Town, or Location of Death: ANNAPOLIS
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 578-52-2103
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT. 7, 1911
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: DAVIDSONVILLE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1513 PATUXENT MANOR ROAD
10f. Zip Code: 21035
10g. Citizen of What Country?: UNITED STATES

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify: WHITE
14. Race - American Indian, Bleck, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired): CLERK
16b. Kind of Business/Industry: DEPARTMENT STORE
17. Fether's Nema (First, Middla, Last): GREGORY AVERA
18. Mother's Neme (First, Middle, Meiden Sumeme): GIOVIANNA MAGGIO
19a. Informant's Neme/Reletionship (Type, Print): JOSEPH G. MAGGIO
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1513 PATUXENT MANNOR ROAD, DAVIDSONVILLE, MD 21035
20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): FORT LINCOLN CEMETERY
Dete: 11/29/1999
20c. Location - City or Town, Stete: BRENTWOOD, MD
21. Signeture of Funeral Sarvice Licensee: Shane E Wells
22. Name end Address of Facility: FORT LINCOLN FUNERAL HOME, 3401 BLADENSBURG ROAD, BRENTWOOD MD 20722

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Final disaese or condition resulting in deeth): a. Cardiomyopathy — Approximate Interval: 2M

Due to (or es a consequence of):

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted avents resulting in deeth) Lest:
b.
Dua to (or as a consequenca of):
c.
Due to (or es a consequence of):
d.

Pert tt. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Inanition; Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was casa rafarrad to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner as steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner stated.

29b. Signeture and title of certifier: L Sprouse MD
29c. License number: D52036
29d. Date signed (Month, Day, Year): 11/29/99

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Gary L Sprouse 2108 N Point Drive Chester MD 21619

State Registrar

31. Data filed (Month, Day, Year): NOV 30 1999
32. Registrer's Signature: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NOV 3 0 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39681

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): HOWARD R. MEYER SR
2. Dete of Deeth: Month NOVEMBER Dey 28 Year 1999
3. Time of Death: 09:36AM
4a. Facility Name (If not Institution, give street end number): ST. MARYS HOSPITAL
4b. City, Town, or Location of Death: LEONARDTOWN
4c. County of Death: ST. MARYS

Funeral Director

5. Sociel Security Number: 042-22-6182
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. lest birthdey): 69 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): May 3,1930
9. Birthplece (Stete or Foreign Country): Connecticut

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Prince George's
10c. City, Town or Location: Clinton
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8500 Mike Shapiro Dr. Apt. 214
10f. Zip Code: 20735
10g. Citizen of Whet Country?: U.S.A.

11. Maritel Stetus: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: 1950-1970
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Reca - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12th; College (1-4or 5+): N/A
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Tech. Sgt. USAF Ret
16b. Kind of Business/Industry: U.S. Government

17. Fether's Neme (First, Middle, Last): Joseph Howard Meyer
18. Mother's Neme (First, Middle, Meiden Surneme): Louise M. Oefinger

19a. Informent's Neme/Reletionship (Type, Print): Howard R. Meyer, Jr. (Son)
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 4745 Shadow Woods Ct. Dumfries, Virginia 22026

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Plece of Disposition (Neme of cemetery, cremetory or other place): Maryland State Veterans Cemetery Dete: Dec.2,1999
20c. Locetion - City or Town, Stete: Cheltenham, Maryland

21. Signeture of Funerel Service Licensee: [signature]
22. Neme end Address of Fecility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Intervel Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in deeth)
e. CARDIAC ARREST

Due to (or es e consequence of):
b. SUSPECTED MYOCARDIAL INFARCTION

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest

Due to (or es e consequence of):
c. CORONARY ARTERY DISEASE

Due to (or es e consequence of):
d. CARDIAC ARRHYTHMIAS 2° CAD

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.
DEMENTIA
CORONARY ARTERY DISEASE

23b. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 [ ] Yes 2 [✓] No

25. Wes case referred to medical exeminer? 1 [ ] Yee 2 [✓] No
26. Place of Deeth (Check only one): Hospitel: 1 [ ] Inpetient 2 [✓] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [✓] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted. 2 [ ] **Medicel Examiner**: On the besis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier: C. Wesley Page MD
29c. License number: MD D39605
29d. Date signed (Month, Dey, Yeer): 11/28/99

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): C. WESLEY PAGE, MD ST. MARYS HOSPITAL LEONARDTOWN, MD. 20650

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

HOWARD R MEYER SR.
Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed (Month, Dey, Yeer): NOV 30 1999
32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39682

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lafayette A. Mavritte
2. Date of Death (Month, Day, Year): November 27, 1999
3. Time of Death: 6:40 AM
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-10-3087
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12/2/08
9. Birthplace (State or Foreign Country): Washington, DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: D.C.
10b. County: N/A
10c. City, Town or Location: Washington
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 5213 Clay Street, N.E.
10f. Zip Code: 20019
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - Americen Indien, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanicl Engineer
16b. Kind of Business/Industry: U.S. Government
17. Father's Name (First, Middle, Last): William Mavritte
18. Mother's Name (First, Middle, Malden Surname): Addie Seldon
19a. Informant's Name/Relationship (Type, Print): Delores M. Upson/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 910 Karlson Ave.,Hyattsville,Md. 20783
20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): Chesapeake Crematory, Inc.
Date: 12-6-99
20c. Location - City or Town, Stete: Beltsville,Md.
21. Signature of Funeral Service Licensee: Larry N. Gratz
22. Name and Address of Facility: H.S.Washington & Sons Co.,Inc. 4925 Burroughs Ave.,N.E.,Wash.,D.C. 20019

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complicetions that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heert failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death): a. SEPSIS

Due to (or as a consequence of): DAYS

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Malnutrition, Supraventricular Tachycardia Hypotension, Acute renal failure Dehydration, Hypernatremia.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was cese referred to medicel examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end manner as stated. 2 ☐ **Medical Examiner:** On the basis of exeminetion and/or investigation, in my opinion, deeth occurred at the time, dete and piece, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D42403
29d. Date signed (Month, Day, Year): 11/27/99

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print): RAJ MATHUR 106 Irving street Washington D.C. 20010

State Registrar

31. Date filed (Month, Day, Year): DEC 01 1999
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(2)

DHMH 16 Rev 6/95

DEC 9 1883

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39683

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last)	2. Dete of Deeth Month Dey Yeer	3. Time of Death
WILLIAM B. MICKENS	NOVEMBER 22,1999	7:40am

4e Facility Neme (If not institution, give street end number)	4b. City, Town, or Location of Death	4c. County of Death
P.G. COUNTY HOSPITAL	CHERVERLY	PRINCE GEORGES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Yeer)	9. Birthplece (Stete or Foreign Country)
579-50-1300	1☒ M 2☐ F	61 Yrs.			JULY 16,1938	VIRGINIA

Usuel Residence of Decedent

10a. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	PRINCE GEORGES	UPPER MARLBORO	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
500 N. HARRY S. TRUMAN DRIVE # 308	20774	UNITED STATES

11. Maritel Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Orlgin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Bleck, White, etc.
1☐ Never Married 2☒ Merried 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Detes:	1☐ Yes ☒ No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grede completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
10		DRIVER/ HEAVY EQUIPMENT	PRIVATE

17. Fether's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
WILLIE MICKENS	EDITH LEWIS

19e. Informent's Name/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
SYLVIA L. MICKENS / WIFE	500 HARRY S. TRUMAN DRIVE # 308 UPPER MARLBORO, MD

20e. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, Stete
1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)	LINCOLN MEMORIAL CEMETERY	11-29-99	SUITLAND, VA

21. Signeture of Funeral Service Licensee	22. Name and Address of Facility
▶ Alex S Pope Jr	ALEXANDER S. POPE FUNERAL 2617 PENN.AVE S.E. WASHINGTON DC 20020

Physician Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset end Deeth

Immedlete Ceuse (Finel diseese or condition resulting in death)
e. myocardial infarction
Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immedlete cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest
b.
Due to (or es e consequence of):
c.
Due to (or es e consequenca of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings evellable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Death (Check only one)
Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Menner of Deeth
1☒ Natural
2☐ Accident
3☐ Suicide
4☐ Homicide
5☐ Pending Investigation
6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) end menner es steted.
2☐ **Medical Examiner:** On the besis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) and manner steted.

29b. Signeture and title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
▶ [signature]	D52222	November 22, 1999

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)
DR. MEERA KANHOUWA 3001 HOSPITAL DR., CHEVERLY, MARYLAND 20785

State Registrar

31. Dete filed (Month, Dey, Yeer)	32. Registrer's Signeture
NOV 30 1999	[signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

4 1/3

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet tha death certificata be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attanding physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Division of Vital Records, P.O. Box 68760,

4

99-6842-033
JAD

Eric Morrow

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39684

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eric Kyle Morrow
2. Date of Death (Month, Day, Year): November 15, 1999
3. Time of Death: 14:47
4a. Facility Name (If not institution, give street and number): 11003 Winsford Avenue
4b. City, Town, or Location of Death: Upper Marlboro
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 213-19-6640
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 27 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 21,1972
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Upper Marlboro
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 11003 Winsford Avenue
10f. Zip Code: 20772
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: Student

17. Father's Name (First, Middle, Last): John James Morrow
18. Mother's Name (First, Middle, Maiden Surname): Judith Arlene Marcino

19a. Informant's Name/Relationship (Type, Print): Monique A. Morrow (Sister)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11003 Winsford Avenue Upper Marlboro, MD 20772

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Center Chapel Cemetery; Date: Nov. 29, 1999
20c. Location - City or Town, State: Steubenville Ohio

21. Signature of Funeral Service Licensee: ▶ St E. Lith
22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton,MD 20735

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Contact Gunshot Wound of Head
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): 11-15-99
28b. Time of Injury: 1440 M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: self-inflicted gunshot wound
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 11003 Winsford Ave Upper Marlboro, MD

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Dennis J Chuten
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): November 16, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J Chuten 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): NOV 2 9 1999
32. Registrar's Signatura

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

NOV 2 3 1959

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39685

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: QUINCY McCALL

2. Deta of Death Month / Day / Yaar: November 21, 1999

3. Time of Death: 4:19 pm

4a. Facility Name *(If not institution, giva street and number)*: DOCTORS COMMUNITY HOSPITAL

4b. City, Town, or Location of Daath: LANHAM

4c. County of Death: Prince Georges

Funeral Director

5. Social Sacurity Number: 245-16-7404

6. Sax: 1 [X] M 2 [ ] F

7. Aga *(In yrs. last birthday)*: 76 Yrs.

If Undar 1 Yaar: Months / Days

If Undar 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: 04-26-23

9. Birthplaca *(Stata or Foraign Country)*: N.C.

Usual Rasidance of Decedant

10a. Stata: MD.

10b. County: Prince Georges

10c. City, Town or Location: Bowie

10d. Inside City Limits: 1 [X] Yas 2 [ ] No

10e. Street and Number: 4706 New York Avenue

10f. Zip Coda: 20720

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorcad

12. Was Decedent Evar in U.S. Armad Forcas? 1 [ ] Yes 2 [X] No If Yas, Giva Yaar or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No *Specify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* BLACK

15. Decedent's Education *(Spacify only highast grada compltad)*: Elamantary/Sacondary (0-12): 3rd. / Collaga (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT use retired)*: TRASH HAULER

16b. Kind of Businass/Industry: N/A

17. Fathar's Nama *(First, Middla, Last)*: DAVE McCALL

18. Mothar's Nama *(First, Middla, Maidan Sumama)*: TEXAS Smith

19a. Informant's Nama/Ralationship *(Typa, Print)*: HATTIE McCALL / wife

19b. Mailing Addrass *(Straat and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda)*: 4706 - New York Ave, Bowie MD. 20720

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*

20b. Placa of Disposition *(Nama of camatary, crematory or othar placa)*: Forest Hills Cemetery

Data: 11/26/99

20c. Location - City or Town, Stata: Clinton

21. Signatura of Funarel Sarvica Licansaa: Melta W. Hackett Jr.

22. Nama and Addrass of Facility: Bianchi Funeral Service c/o Hacketts Funeral Chapel, Inc. 814 - Upshur Street, N.W.

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complications that caused the daath. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart feilura. List only ona cause on each lina.

Approximata Intarval Between Onset and Death

Immediate Causa (Final disaasa or condition rasulting in death)

a. Acute Myocardial Infarction — 24 hours

Dua to (or as a consequanca of):

b. Acute Renal Failure — 7 days

Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Ceuse (Disease or Injury that initiated avants rasulting in daath) Last

Due to (or as a consaquance of):

c. Non Hodgkins Lymphoma — 6 weeks

Dua to (or as a consequance of):

d.

Part II. **Othar significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.

Hypertension
urethral sclerosis (stricture)

23b. **Did tobacco uaa contribute to the causa of death?** 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings available prior to compilation of causa of death? 1 [ ] Yas 2 [ ] No

25. Wes casa raferrad to madical examinar? 1 [ ] Yas 2 [X] No

26. Placa of Daath *(Chack only ona)*: Hospital: 1 [X] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA — Other: 4 [ ] Nursing Homa 5 [ ] Rasidance 6 [ ] Othar *(Specify)*

27. Mannar of Daath: 1 [X] Naturel 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding invastigation 6 [ ] Could not ba datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurred

28e. Placa of Injury - At homa, farm, streat, factory, office building, atc. *(Specify)*

28f. Location *(Straet and Numbar or Rural Routa Numbar, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Cartifiar *(Check only one)*: [X] **Certifying Phyaician**: To tha best of my knowladga, daath occurred at tha tima, data and placa, and dua to tha cause(s) and manner as statad. [ ] **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha cause(s) and manner stated.

29b. Signatura and tita of cartifiar: Hema P. Yadlapalli M.D.

29c. Licansa number: A21883

29d. Data signad *(Month, Day, Yaar)*: 11/22/99

30. Nama and addrass of parson who completad causa of daath (Item 23a) (Typa, Print): HEMA P. YADLA M.D. 9470 ANNAPOLIS Rd LANHAM MD 20706

State Registrar

31. Data filad *(Month, Day, Yaar)*: NOV 29 1999

32. Ragistrar's Signatura: B. Hacks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

McCall, Quincy

(2)

DHMH 16 Rav 6/95

APR 2 3 1984

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39686

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DOROTHY H. McKENZIE
2. Date of Death (Month, Day, Year): NOV. 23, 1999
3. Time of Death: 4:10 PM
4a. Facility Name (If not institution, give street and number): NATIONAL LUTHERAN HOME
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY CO.

Funeral Director

5. Social Security Number: 213-54-7671
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT.15,1913
9. Birthplace (State or Foreign Country): WASH.,DC

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9701- VEIRS DR.
10f. Zip Code: 20850
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedant Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedant of Hispanic Origin? (Spacify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: AT HOME

17. Father's Neme (First, Middle, Last): JOHN K. HILLERS
18. Mother's Name (First, Middle, Maiden Surname): LELA E. ELISON

19a. Informant's Name/Ralationship (Type, Print): MRS.LOUISE FAULKNER-DAUGHTER
19b. Mailing Address (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Code): -9722-CLAGETT FARM DR.,POTOMAC,MD.20854

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Name of cemetery, cramatory or other place): PARKLAWN CEMETERY
Date: 11/29/99
20c. Location - City or Town, State: -ROCKVILLE,MD.

21. Signature of Funeral Service Licansee: W. M. Hysong
22. Name and Address of Facility: HYSONG CO.,INC.FUNERAL HOME 1300- N ST.,NW, WASH.,DC

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — 1 Week

Due to (or as a consequenca of):
b. parkinson's disease — Years

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last

Due to (or as a consequence of):
c. Chronic obstructive pulmonary disease — year

Due to (or as a consequence of):
d. Anemia — 2 weeks

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

urinary tract infection
Advanced dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residanca 6☐ Other (Spacify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifier (Check only one): 1☒ **Certifying Physician:** To tha bast of my knowladga, daath occurred at tha tima, data and place, and dua to the causa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigetion, in my opinion, death occurred at the time, deta and placa, and dua to the cause(s) and mannar stated.

29b. Signature and title of cartifier: Charles W. Karesh MD
29c. License number: D21726
29d. Dete signed (Month, Day, Year): November 24, 1999

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): DR. CHARLES W. KARESH- 9701- VEIRS DR., ROCKVILLE,MD.

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999
32. Registrar's Signatura: Barbara B. Goode

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with tha Maryland Department of Haalth and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by tha attanding physician and completely filled in by tha funeral director, page 2 should be detached for usa as the burial-transit

NOV 5 1928

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39687

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MICHAEL L. MORRIS
2. Date of Death (Month, Day, Year): Dec. 4, 1999
3. Time of Death: 1:25 AM
4a. Facility Name *(If not institution, give street and number)*: Fallston General Hospital
4b. City, Town, or Location of Death: Fallston
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 220-42-9008
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 57 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth *(Month, Day, Year)*: 8/9/1942
9. Birthplace *(State or Foreign Country)*: MAryland

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Cardiff
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1700 Chestnut Street
10f. Zip Code: 21160
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mail CArrier
16b. Kind of Business/Industry: Post Office

17. Father's Name *(First, Middle, Last)*: Charles E. MOrris
18. Mother's Name *(First, Middle, Maiden Surname)*: Bertha Jakubowski

19a. Informant's Name/Relationship *(Type, Print)*: Shirley L. Morris- wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1700 Chestnut St., Cardiff, MD 21160

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Slate Ridge Cemetery
Date: 12/7/99
20c. Location - City or Town, State: Delta,PA

21. Signature of Funeral Service Licensee: Jeffrey P. Lovelidge
22. Name and Address of Facility: Harkins Funeral Home, Inc.,600 Main St. Delta,PA 17314

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Ventricular Fibrillation
Due to (or as a consequence of):
b. Myocardial Infarction
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Coronary Artery Disease — 5+ yrs
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Janne Olson MD
29c. License number: D15044
29d. Date signed *(Month, Day, Year)*: Dec. 6, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Janne Olson, M.D. Webb Lane, Fawn Grove, PA 17321

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 07 1999
32. Registrar's Signature: B. Spatal

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39688

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Malcolm Scott Mullendore
2. Date of Death (Month, Day, Year): December 4, 1999
3. Time of Death: 7:20 P.M.
4e. Facility Name (If not institution, give street and number): 9650 Old National Pike
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 213-68-6361
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 44 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 21, 1955
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 9650 Old National Pike
10f. Zip Code: 21740
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer
16b. Kind of Business/Industry: Agriculture

17. Father's Name (First, Middle, Last): James Richardson Mullendore
18. Mother's Name (First, Middle, Maiden Surname): Donna Lee Martin

19a. Informant's Name/Relationship (Type, Print): Donna L. Pike/Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1102 Whitestone Drive Martinsburg, WV 25401

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory | Date: Dec. 6, 1999
20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Osborne Funeral Home 425 S. Conococheague St. Williamsport, MD 21795

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Chronic Obstructive Pulmonary Disease	Years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Severe Sleep apnea; Morbid Obesity

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
26b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D
29c. License number: D41786
29d. Date signed (Month, Day, Year): 12/6/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Heuchery MD, 12821 Oak Hill Ave, Hagerstown MD 21742

State Registrar

31. Date filed (Month, Day, Year): DEC 06 1999
32. Registrar's Signature: [signature] G. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39689

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Edward Miller Jr.

2. Date of Death (Month, Day, Year): December 3 1999

3. Time of Death: 17:36

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 133-30-9241

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 59 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 31, 1939

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Md.

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1011 B Georgia Ave.

10f. Zip Code: 21740

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 60-64

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bus Driver

16b. Kind of Business/Industry: Transportation

17. Father's Neme (First, Middle, Last): Joseph Edward Miller Sr.

18. Mother's Name (First, Middle, Maiden Surname): Elsie Unknown

19a. Informant's Name/Relationship (Type, Print): Michelle D. Miller (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 456 Valley Hill Rd. Riverdale, GA 30274

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory

Date: Dec.7,1999

20c. Location - City or Town, State: Smithsburg, Md.

21. Signature of Funeral Service Licensee: Dennis L. Davis

22. Name end Address of Fecility: Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)

a. CARDIAC ARREST

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c. CARDIAC ARRTHMIA

Due to (or as a consequence of):

d. CONGESTIVE HEART FAILURE

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE

HEMODIALYSIS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D53548

29d. Date signed (Month, Day, Year): 12/4/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Monzur 12931 Oak Hill Avenue Hagerstown Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Joseph Edward Miller

State Registrar

31. Date filed (Month, Day, Year): DEC 07 1999

32. Registrar's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#17 PER F.H. G778 12-20-99 J.A.

Certificate of Death

Reg. No. 99 39690

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Della Louise Michal	Dec. 01, 1999	0600

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
925 Security Road	Hagerstown	Washington County

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-40-3667	1☐ M 2☒ F	55 Yrs.			March 16,1944	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Washington Co.	Hagerstown	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
925 Security Road	21742	U.S.A.

11. Marital Status	12. Was Decedent Ever In U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Detes:	1☐ Yes 2☒ No *Specify:*	*Specify:* White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	Bookkeeper	Self employed

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
William Dorsey EDWARDS	Hilda C. Nicola

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Dina E. Rivera/Sister	7001 Nightingale Place, Lanham, Maryland 20706

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1☒ Buriat 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Shiloh Cemetery	Dec.3	Moatsville, WV

21. Signature of Funerel Service Licensee: Kelly A Zimmerman

22. Name and Address of Facility: Douglas A. Fiery Funeral Home 1331 Eastern Blvd.,N.,Hagerstown,Maryland 21742

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hypoxia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
b. Metastatic Disease to Multiple Organs (incl. heart/brain)

Due to (or as a consequence of):
c. Lung Cancer

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uea contributa to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings availeble prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Ptace of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how Injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Mark S. Baron MD	D0053071	December 1, 1999

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)
Mark S. Baron, M.D., 11110 Medical Campus Road, Suite 226, Hagerstown, MD 21742

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 02 1999	Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39691

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Walter Taylor Malcolm
2. Date of Death Month Day Year: NOV. 26, 1999
3. Time of Death: 8:25 PM.
4a. Facility Name *(If not institution, give street and number)*: Homewood Nursing Home
4b. City, Town, or Location of Death: Williamsport
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 219-12-1231
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 31, 1921
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Washington
10c. City, Town or Location: Clear Spring,
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 12403 Nesbitt Ave.
10f. Zip Code: 21722
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 5th grade | College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: sheet metal worker
16b. Kind of Business/Industry: aircraft mfg.

17. Father's Name *(First, Middle, Last)*: John Robert Malcolm
18. Mother's Name *(First, Middle, Maiden Surname)*: Edith Day

19a. Informant's Name/Relationship *(Type, Print)*: Pamela Cottrill
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 395 Riverview Dr. McVeytown, PA. 17051

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cedar Lawn Park
Date: Nov. 30, 1999
20c. Location - City or Town, State: Hagerstown, MD

21. Signature of Funeral Service Licensee: Donald A Thompson
22. Name and Address of Facility: Donald Edwin Thompson Funeral Home, Inc P.O.Box 310 Clear Spring, MD 21722

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

28a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — 1 year

Due to (or as a consequence of):
b. Arteriosclerotic cardiovascular disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Renal insufficiency
Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D26606
29d. Date signed *(Month, Day, Year)*: 11/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Arthur Haus 747 Northview Dr. Hagerstown MD 21742

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 30 1999
32. Registrar's Signature: B. Sparks

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

11-26-99 825 pm

Walter Malcolm

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39692

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MAUDE GLADYS MINK

2. Date of Death: Month November Day 27 Year 1999

3. Time of Death: 2156

4a. Facility Name (If not institution, give street and number): FALLSTON GENERAL HOSPITAL

4b. City, Town, or Location of Death: FALLSTON

4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 216-52-7511

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 18, 1909

9. Birthplace (State or Foreign Country): Virginia

Usual Residance of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1011 Winfield Dr.

10f. Zip Code: 21015

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yes, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 5 College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Fathar's Nama (First, Middla, Last): Troy (u/k) Spencer

18. Mothar's Nama (First, Middle, Maiden Surnama): Dora Belvie Reedy

19a. Informant's Name/Ralationship (Type, Print): Robert A. Mink / Son

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 16 Oakmont Circle, New Freedom, Pa 17349

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Nama of cematery, cremetory or other place): Bel Air Memorial Gardens

Data: 12-1-99

20c. Location - City or Town, Stata: Bel Air, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: McComas Funeral Home, P.A. 50 W. Broadway Street, Bel Air, Maryland 21014

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not entar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Intervel Between Onset and Death

Immediata Causa (Final disaasa or condition rasulting in death)

a. Cardiogenic shock

Dua to (or as a consequance of):

Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last

b. Acute myocardial infarction

Dua to (or as a consequence of):

c.

Dua to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Hypercholesterolemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was casa rafarred to medical examinar? 1☐ Yas 2☒ No

26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifiar (Check only one) 1☒ Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and place, end dua to the cause(s) and manner as stated. 2☐ Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signatura and title of certifiar: [signature] MD

29c. License number: D 36425

29d. Data signed (Month, Day, Year): November 28, 1999

30. Nama and address of person who completed cause of daath (Item 23a) (Type, Print): Adam Ahl, MD 206 Hays Street Bel Air MD 21014

State Registrar

31. Data filed (Month, Dey, Year): NOV 30 1999

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Mink, Maude Gladys

6

99-7171-031
DDG
MICHAEL MURAD

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39693

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Michael Paul Murad
2. Date of Death (Month, Dey, Year): NOVEMBER 29, 1999
3. Time of Death: 2058 PM
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 213-58-6670
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 42 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 7, 1956
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Germantown
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 12229 Major Drive
10f. Zip Code: 20874
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Process Control Engineer
16b. Kind of Business/Industry: Mobile Oil
17. Father's Name (First, Middle, Last): Ronald V. Murad
18. Mother's Name (First, Middle, Maiden Surname): Gloria J. Dippold
19a. Informant's Name/Relationship (Type, Print): Constance S. Murad - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12229 Major Drive, Germantown, Maryland 20874
20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entombment
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Mausoleum
Date: 12/6/99
20c. Location - City or Town, State: Silver Spring, Maryland
21. Signature of Funeral Service Licensee: Robert L. Williams
22. Name and Address of Facility: Olin L. Molesworth P.A., Funeral Home, 26401 Ridge Road, Damascus, Maryland 20872-0117

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Dey Year): 11/29/99
28b. Time of Injury: 8PM
28c. Injury at Work? 1 ☐ Yes 2 ☑ No
28d. Describe how injury occurred: Passenger in motor vehicle collided with another vehicle
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Street, Route 355 at Gunner Branch Rd
28f. Location (Street and Number or Rural Route Number, City or Town, State): Germantown, Md.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

29b. Signature and title of Certifier: J. Pertame MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Dey, Year): DECEMBER 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 06 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

99-7172-031
crn
Matthew James Murad

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 39694

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Matthew James Murad	November 29, 1999	8:58 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Shady Grove Adventist Hospital	Rockville	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-72-8254	1 [X] M 2 [ ] F	31 Yrs.			Dec. 30, 1967	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Germantown	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
12229 Major Drive	20874	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yas, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	Certified Public Accountant	NEXTEL, Corporation
	4		

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ronald V. Murad	Gloria J. Dippold

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ronald V. Murad - Father	12229 Major Drive, Germantown, Maryland 20874

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Data	20c. Location - City or Town, State
1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify)	Entombment	Gate of Heaven Mausoleum	12/6/99 Silver Spring, Maryland

21. Signature of Funeral Service Licensee: Robert L. Williams

22. Name and Address of Facility: Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one causa on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [X] Yes 2 [ ] No	1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [X] Yes 2 [ ] No	Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	11/29/99	8AM M	1 [ ] Yes 2 [X] No	Driver of motor vehicle collided with another vehicle

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Street; Route 355 at Gunner Branch Rd; Germantown, Md.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J Pestaner, MD.	O.C.M.E.	December 01, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 06 1999	Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39695

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Ruth Elizabeth Mackelmann
2. Dete of Deeth: Month November Dey 24 Yeer 1999
3. Time of Deeth: 7:05 AM
4e. Fecility Neme *(If not institution, give street and number)*: Holy Cross Hospital
4b. City, Town, or Location of Deeth: Silver Spring
4c. County of Deeth: Montgomery

Funeral Director

5. Sociel Security Number: 331-34-0502
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 89 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Year)*: Jan 2, 1910
9. Birthplece *(State or Foreign Country)*: Illinois

Usual Residence of Decedent

10e. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 3620 Littledale Road, #210
10f. Zip Code: 20895
10g. Citizen of Whet Country?: United States
11. Merifel Stefus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indian, Bleck, White, efc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 5+
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Social Worker
16b. Kind of Business/Industry: Non-Profit Organizations
17. Fether's Name *(First, Middle, Last)*: Darwin Fordyce Sanderson
18. Mother's Neme *(First, Middle, Maiden Surname)*: Sylvia Parsons
19a. Informent's Name/Relationship *(Type, Print)*: Mary Helen Silva (daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 404 Willington Drive, Silver Spring, Maryland 20904
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory
Dete: 11-26-99
20c. Location - City or Town, Stete: Beltsville, Maryland
21. Signefure of Funeral Service Licensee: Carol A Dehn
22. Neme end Address of Facility: Rapp Funeral & Cremation Services, Stephen D. Lohrmann, PA 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the deeth. Do nof enfer the mode of dying, such es cardiac or respirefory errest, shock, or heart failure. List only one cause on each line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel disease or condition resulting in death)
e. Pneumonia — 5 days

Due to (or es e consequenca of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in deeth) Lest
b. Multiple Myeloma — years

Due to (or as e consequenca of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other eignificant conditions** confributing to deeth but not resulting in the underlying cause given in Part I.

Atrial Flutter, new onset

Plasmacytoma of Thoracic Spine

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invesfigafion 6☐ Could not be determined

28e. Dete of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of exemination end/or Investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner steted.

29b. Signature end title of certifier: Ruth Kevess-Cohen M.D.
29c. License number: D33159
29d. Date signed *(Month, Day, Year)*: Nov. 24, 1999

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Ruth Kevess-Cohen, M.D., 8700 Georgia Avenue, #400, Silver Spring, MD 20910

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 29 1999
32. Registrer's Signature: Renee G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39696

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nancy L. MacKay

2. Data of Death: Month November Day 26 Year 1999

3. Time of Death: 5:00am

4a. Facility Name (If not institution, give street and number): 10410 Fawcett Street Apt #4

4b. City, Town, or Location of Death: Kensington

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 056-26-4894

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 67 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 11, 1932

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Kensington

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10410 Fawcett Street Apt #4

10f. Zip Code: 20895

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assisting Manager

16b. Kind of Business/Industry: Fabrics

17. Father's Name (First, Middle, Last): Robert T. Young

18. Mother's Name (First, Middle, Maiden Surname): Mirian Keyler

19a. Informant's Name/Relationship (Type, Print): George D. MacKay/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10410 Fawcett Street Apt #4, Kensington, MD 20895

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Metropolitan Crematory — Date: Nov 29 1999

20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: ▶ Tracy A. Stuver

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W, Silver Spring, MD 20901

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Small cell lung cancer — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. metastatic lung cancer, to abdominal organs — 2 months

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Neena J. Shapiro

29c. License number: D35336

29d. Date signed (Month, Day, Year): 11/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DEENA J. SHAPIRO MD 10810 CONNECTICUT AVE KENSINGTON MD 20895

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999

32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39697

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Caroline A. Maida

2. Date of Death (Month, Day, Year): December 1, 1999

3. Time of Death: 8:00 am

4a. Facility Name (If not institution, give street and number): Montgomery General Hospital

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 090-09-4074

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept 13, 1917

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13410 Oriental Street

10f. Zip Code: 20853

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Blaser

18. Mother's Name (First, Middle, Maiden Surname): Margaret Sold

19a. Informant's Name/Relationship (Type, Print): Frank C. Maida / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13410 Oriental Street, Rockville, MD 20853

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park

Date: 12/3/99

20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: Tracy A. Shuer

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd, W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic lymphocytic leukemia

Due to (or as a consequence of):

b. Thrombocytopenia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph Kaplan

29c. License number: D35635

29d. Date signed (Month, Day, Year): December 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Kaplan 18111 Prince Philip Dr, Olney, MD 20832

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999

32. Registrar's Signature: Bruce D. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39698

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Diane Anastasia McDaniel
2. Date of Death (Month, Day, Year): NOVEMBER 24, 1999
3. Time of Death: 1939
4a. Facility Name (If not institution, give street and number): LAUREL REGIONAL HOSPITAL
4b. City, Town, or Location of Death: LAUREL
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 327-48-7944
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 47 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 21, 52
9. Birthplace (State or Foreign Country): Chicago, IL

Usual Residence of Decedent

10a. State: Colorado
10b. County:
10c. City, Town or Location: Denver
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 131 West Maple Avenue
10f. Zip Code: 80223
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: State Government

17. Father's Name (First, Middle, Last): Willie Oliver McDaniel
18. Mother's Name (First, Middle, Maiden Surname): Nell Marie McDaniel

19a. Informant's Name/Relationship (Type, Print): Nell McDaniel/Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6979 Mayfair Terr., Laurel, MD 20707

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory | Date: 11/30/99
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Thomas Latney Jr
22. Name and Address of Facility: Latney's Funeral Home 20011
3831 Georgia Ave., NW-Washington, DC

Physician /Medical Examiner

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Mario F. Golle Jr. MD
29c. License number: D33954
29d. Date signed (Month, Day, Year): NOVEMBER 27, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARIO F. GOLLE JR MD 3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785

State Registrar

31. Date filed (Month, Day, Year): NOV 26 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39699

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lorraine McGowan
2. Date of Death — Month: November Day: 29 Year: 1999
3. Time of Death: 6:15 AM
4e. Facility Name (If not institution, give street and number): 12309 Sir Lancelot Drive
4b. City, Town, or Location of Death: Glendale
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 579-32-0259
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 1, 1914
9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10e. State: N/A
10b. County: N/A
10c. City, Town or Location: Washington, D.C.
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 506 T Street, N.W.
10f. Zip Code: 20001
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrative Assistant
16b. Kind of Business/Industry: Emergency Medical Services
17. Father's Name (First, Middle, Last): Roscoe Vaughn
18. Mother's Name (First, Middle, Maiden Surname): Mary Elizabeth Waring
19a. Informant's Name/Relationship (Type, Print): Andrea Curry Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12309 Sir Lancelot Dr., Glendale, MD 20769
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: 12/4/99
20c. Location - City or Town, State: Silver Spring, MD
21. Signature of Funeral Service Licensee: Lynne T McGuire
22. Name and Address of Facility: McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. METASTATIC BREAST CANCER — 2 MONTHS
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown
24e. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? N/A 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) daughters home
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Anthony Adeye MD
29c. License number: A 36091
29d. Date signed (Month, Day, Year): 11/30/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANTHONY ADEYE M.D. 6104 OLD BRANCH AVE TEMPLE HILLS MD 20748

State Registrar

31. Date filed (Month, Day, Year): DEC 02 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39700

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carroll A. Miller
2. Date of Death (Month, Day, Year): November 27, 1999
3. Time of Death: 2:50 am
4a. Facility Name (If not institution, give street and number): Wilson Health Care
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-09-1723
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 15, 1909
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 333 Russell Avenue #503
10f. Zip Code: 20877
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Institutional Food Salesman
16b. Kind of Business/Industry: Frozen Foods

17. Father's Name (First, Middle, Last): Samuel Miller
18. Mother's Name (First, Middle, Maiden Surname): Jennie Poteet

19a. Informant's Name/Relationship (Type, Print): Betty M. Miller / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 333 Russell Avenue, Gaithersburg, MD 20877

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery | Date: Nov 30 1999
20c. Location - City or Town, State: Suitland , MD

21. Signature of Funeral Service Licensee: ▶ Tracy A. Shriver.
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PROSTATIC CARCINOMA	5 YEARS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ALZHEIMER'S DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Charles M Benner
29c. License number: D31563
29d. Date signed (Month, Day, Year): November 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES M BENNER MD, 11251 LOCKWOOD DRIVE, SILVER SPRING, MD 20904

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

b

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39701

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret Catherine Miller

2. Date of Death (Month, Day, Year): November 26, 1999

3. Time of Death: 2-30 AM

4a. Facility Name (If not institution, give street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 444-26-6512

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 8, 1921

9. Birthplace (State or Foreign Country): Missouri

Usual Residence of Decedent

10a. State: VA

10b. County: Wythe

10c. City, Town or Location: Grahams Forge

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 163 Southcrest Drive

10f. Zip Code: 24360

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Leo Ordener

18. Mother's Name (First, Middle, Maiden Surname): Katherine Hoff

19a. Informant's Name/Relationship (Type, Print): Connie Hanna - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8449 Miramar Road Pasadena, Maryland 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Draper Valley Pent. Hol. Church Cemetery

Date: 12/3/99

20c. Location - City or Town, State: Wythe County, VA

21. Signature of Funeral Service Licensee: Karen J. Woodell

22. Name and Address of Facility: Metropolitan Funeral Service, Inc. 5517 Vine Street Alexandria, VA 22310

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ISCHEMIC CARDIOMYOPATHY — 6 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC OBSTRUCTIVE LUNG DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: , MD

29c. License number: D46962

29d. Date signed (Month, Day, Year): NOVEMBER 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. SHIRAZI, MD. NORTH ARUNDEL HOSPITAL. MD 21061.

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

Jr Margaret Miller

1816

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39702

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM E. MILLER
2. Data of Death Month Day Year: NOV. 20, 1999
3. Time of Death: 6:43 PM.
4a. Facility Name *(If not institution, give street and number)*: SUBURBAN HOSPITAL
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-54-4002
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 92 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: 8/18/1907
9. Birthplace *(State or Foreign Country)*: HARDIN, KY.

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: BETHESDA
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 9707 OLD GEORGETOWN ROAD
10f. Zip Code: 20814
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: LAWYER
16b. Kind of Business/Industry: LAW

17. Father's Name *(First, Middle, Last)*: T.A.L. MILLER
18. Mother's Name *(First, Middle, Maiden Surname)*: LENA LASSITER

19a. Informant's Name/Relationship *(Type, Print)*: WILLIAM T. MILLER - SON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7317 BANNOCKBURN RIDGE COURT BETHESDA, MD. 20817

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ROCK CREEK CEMETERY — Date: 11/23/99
20c. Location - City or Town, State: WASH. D.C.

21. Signature of Funeral Service Licensee
22. Name and Address of Facility: JOSEPH GAWLER'S SONS 5130 WISC. AVE. WASHINGTON, DC. 20016

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	MYOCARDIAL INFARCTION	2 DAYS
Due to (or as a consequence of): b.	PNEUMONIA	4 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	PARKINSONS'S DISEASE	10 YEARS
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D4243
29d. Date signed *(Month, Day, Year)*: November 22, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): B. Robert Mobayen, MD 5530 Wisconsin Ave #1455, Chevy Chase MD 20815

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 26 1999
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

11/20/99 b

WILLIAM E. MILLER

30

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39703

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Eileen Mitchell
2. Date of Death Month Day Year: November 20, 1999
3. Time of Death: 8:00pm
4e Facility Neme (If not institution, give street and number): Casey House
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-68-9349
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Mar. 21, 1925
9. Birthplace (State or Foreign Country): W.I.

Usual Residence of Decedant

10a. Stete: DC
10b. County: NA
10c. City, Town or Location: Washington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 1365 Kennedy Street, N. W.
10f. Zip Code:
10g. Citizen of What Country?: United States
11. Meritel Stetus: 1☒ Never Married 2☐ Merried 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurses' Assistant
16b. Kind of Business/Industry: Health Care
17. Father's Neme (First, Middle, Last): Ellis Dillon
18. Mother's Name (First, Middle, Maiden Surnama): Elcina Mitchell
19e. Informant's Neme/Relationship (Type, Print): Wayne Bartholomew - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12307 Braxfield Ct. #7, Rockville, MD 20852
20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Forest Hills Cem.
Data: 11/27/99
20c. Location - City or Town, Stata: Clinton, MD
21. Signature of Funeral Service Licensee: R. N. Horton
22. Name and Address of Facility: R. N. Horton Co. Morticians, Inc. 600 Kennedy St., N.W., Wash., DC 20011

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Pert1. Entar tha disease, or complications that caused the death. Do not entar the mode of dying, such es cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on eech lina.

Approximata Interval Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in death)
a. Metastatic Uterine Carcinoma — 3 yrs.

Dua to (or as e consequence of):

Sequentially list conditions, if any, laading to immediete causa. Entar Underlying Cause (Disaese or injury that initieted events resulting in death) Last
b.
Due to (or es a consequence of):
c.
Due to (or as a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only ona)
Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Homa 5☐ Residence 6☒ Othar (Specify) Hospice
27. Mannar of Death: 1☒ Naturel 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29e. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: Mark S. Godec, MD
29c. License number: D37620
29d. Date signed (Month, Day, Year): November 21, 1999

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Mark S. Godec, M.D. 6001 Muncaster Mill Road, Rockville, MD 20855 @)*%%

State Registrar

31. Date filed (Month, Dey, Year): NOV 30 1999
32. Registrar's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39704

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dr. Jocelyn Elizabeth Mitchell
2. Date of Death (Month, Day, Year): November 24, 1999
3. Time of Death: 2:20pm
4a. Facility Name *(If not institution, give street and number)*: Sycamore Acres Home
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-60-6942
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 97 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 1, 1902
9. Birthplace *(State or Foreign Country)*: Connecticut

Usual Residence of Decedent

10a. State:
10b. County: N/A
10c. City, Town or Location: Washington, DC
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1725 K Street, N.W.
10f. Zip Code: 20006
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Physician
16b. Kind of Business/Industry: Medical
17. Father's Name *(First, Middle, Last)*: Charles Johnson
18. Mother's Name *(First, Middle, Maiden Surname)*: Ellen Bell
19a. Informant's Name/Relationship *(Type, Print)*: Renee I. Fox (Attorney)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1725 K. Street, N.W., Washington, DC 20006
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory — Date: 11/26/99 — 20c. Location - City or Town, State: Alexandria, Virginia
21. Signature of Funeral Service Licensee: Robert K. DeVol
22. Name and Address of Facility: DeVol Funeral Home, 2222 Wisconsin Avenue NW, Washington, DC 20007

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cancer of The Lung	2 Years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Benjamin Avrunin, M.D.
29c. License number: D08381
29d. Date signed *(Month, Day, Year)*: November 26, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Benjamin Avrunin, M.D. 18111 Prince Philip Drive #209, Olney, MD 20832

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 30 1999
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39705

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Erna L. Morgan
2. Date of Death (Month, Day, Year): November 29, 1999
3. Time of Death: 3:25 PM
4a. Facility Name (If not institution, give street and number): 14744 Maine Cove Terrace
4b. City, Town, or Location of Death: North Potomac
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 365-05-0291
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): November 6, 1916
9. Birthplace (State or Foreign Country): Michigan

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: North Potomac
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 14744 Maine Cove Terrace
10f. Zip Code: 20878
10g. Citizen of What Country?: United States

11. Meritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: City Government

17. Father's Name (First, Middle, Last): Hermann Friederich Leidich
18. Mother's Name (First, Middle, Maiden Surname): Maria Schinck

19a. Informant's Name/Relationship (Type, Print): John N. Morgan/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14744 Maine Cove Terrace, North Potomac, MD 20878

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Montgomery Crematorium, Inc. — Date: Nov. 30, 1999
20c. Location - City or Town, Stete: Bethesda, Montgomery

21. Signature of Funeral Service Licensee: ▶ [signature] MO1126
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

		Approximete Interval Between Onset end Death
Immediete Ceuse (Final disease or condition resulting in death) e.	Pneumonia	2 Days
Due to (or as e consequenca of):		
Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last — b.	Normopressure Hydrocephalus	18 Months
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Accident

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end piece, and due to the ceuse(s) and menner steted.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D0051889
29d. Date signed (Month, Dey, Year): 11-30-99

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Deborah B. Rost, M.D. 15225 Shady Grove Road, Suite 102, Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year): DEC 01 1999
32. Registrar's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39706

Amended Item#19b perFH G778 12/20/99 EW

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DORA MORRIS
2. Date of Death: Month NOV. Day 27, Year 1999
3. Time of Death: 4:00 A.M.
4a. Facility Name *(If not institution, give street and number)*: ROCKVILLE NURSING HOME
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-44-0325-A
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 95 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: FEB.6, 1904
9. Birthplace *(State or Foreign Country)*: Great Britian

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 303-Adclare Road
10f. Zip Code: 20850
10g. Citizen of What Country?: UNITED STATES
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12TH — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SALES
16b. Kind of Business/Industry: RETAIL
17. Father's Name *(First, Middle, Last)*: MARK TIKTIN
18. Mother's Name *(First, Middle, Maiden Surname)*: ANNE COHEN
19a. Informant's Name/Relationship *(Type, Print)*: LIONEL MORRIS
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 16021-Chester Mill ~~Road~~ Terrace, Silver Spring, Maryland 20906
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: King David Memorial Garden 1999 — 11/28
20c. Location - City or Town, State: Falls Church, Virginia
21. Signature of Funeral Service Licensee: Barry B. Dobkin
22. Name and Address of Facility: 232-CARROLL STREET, NORTHWEST WASHINGTON, D.C. 20012 — STEIN/HEBREW F.H.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SENILE DEMENTIA	
Due to (or as a consequence of):	CONGESTIVE HEART FAILURE	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mark H. Eig
29c. License number: D24886
29d. Date signed *(Month, Day, Year)*: NOVEMBER 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mark H. Eig. M.D., 10801-Lockwood Drive, Silver Spring, Maryland 20901

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 29 1999
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

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11/29/99 (see #31)
Incorrect date 11/20/99 applied. White out used.
11/29/99 ~~Applied~~ entered. B. McWilliams

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39707

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET NELMS

2. Date of Death: Month November Day 23, Year 1999

3. Time of Death: 4:15 pm

4a. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

Funeral Director

5. Social Security Number: 212-22-9221

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 20, 1926

9. Birthplace (State or Foreign Country): Lancaster VA.

Usual Residence of Decedent

10e. State: MD.

10b. County:

10c. City, Town or Location: BALTIMORE MARYLAND

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 8510 GREEN LANE GLEN OAKS MD.

10f. Zip Code: 21244

10g. Citizen of What Country? U.S.A.

11. Maritel Stetus: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify: AFROAMERICAN

14. Race - American Indien, Black, White, etc. Specify: AFROAMERICAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 10 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DOMESTIC

16b. Kind of Business/Industry: HOUSE KEEPING

17. Father's Name (First, Middle, Last): AUGUSTUS NELMS

18. Mother's Name (First, Middle, Maiden Surname): LOLIS BEA NELMS

19a. Informent's Name/Relationship (Type, Print): MARVA N. CARTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 401 Sussex Drive Lindenwold New Jersey 08021

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): FIRST BAPTIST CHURCH

Dete: 11/27/

20c. Location - City or Town, State: Heathsville Virginia

21. Signature of Funeral Service Licensee: Barry O. Waddy

22. Name and Address of Facility: BERRY O. WADDY 6784 Mary Ball Road Lancaster VA. 22503 P.O. Box 305

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory arrest, shock, or heert failure. List only one ceuse on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequenca of):

b. Sepsis

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) Hospital: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29e. Certifier (Check only one) 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) end manner es steted. 2☐ **Medical Examiner**: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.J. Ogale

29c. License number: 89353

29d. Dete signed (Month, Day, Year): 11/23/99

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): Manisha Ogale, M.D. Co Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Yeak): NOV 30 1999

32. Registrar's Signeture: Bonnie B. Franke

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Margaret Nelms

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39708

Name: Mary Elizabeth Norris

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY ELIZABETH NORRIS

2. Date of Death: Month December Day 7 Year 1999

3. Time of Death: 2:20 AM

4a. Facility Name (If not institution, give street and number): Reeders Memorial Home

4b. City, Town, or Location of Death: Boonsboro

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 220-54-3848

6. Sex: 1☐ M 2☒ F (X)

7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr 17, 1932

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Keedysville

10d. Inside City Limits: 1☐ Yes 2☒ No (X)

10e. Street and Number: 4912 Porterstown Road

10f. Zip Code: 21756

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced (X)

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No (X) If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No (X) Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Charles William Norris

18. Mother's Name (First, Middle, Maiden Surname): Martha Jane Hayes

19a. Informant's Name/Relationship (Type, Print): Tawanna Sue Fisher / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4912 Porterstown Road, Keedysville, MD 21756

20a. Method of Disposition: 1☒ Burial (X) 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Community Cemt

Date: 12/10/99

20c. Location - City or Town, State: Harmony, Maryland

21. Signature of Funeral Service Licensee: Patty L Ricketts

22. Name and Address of Facility: Ricketts Funeral Home, 504 Main Street, Myersville, MD 21773

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. lung cancer — 6 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

emphysema

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably (X) 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No (X)

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No (X)

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home (X) 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural (X) 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (X) 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D32518

29d. Date signed (Month, Day, Year): 12/7/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Robert Guedenet 100 Geeting Lane, Keedysville, Maryland 21756/301-432-2222

State Registrar

31. Date filed (Month, Day, Year): DEC 08 1999

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39709

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anne Marie O'Connor
2. Date of Death (Month, Day, Year): November 29, 1999
3. Time of Death: 3:25 pm
4e. Facility Name (If not institution, give street and number): Rockville Nursing Home
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-10-4478
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 21, 1910
9. Birthplace (State or Foreign Country): DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Olney
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 17605 Prince David Drive
10f. Zip Code: 20832
10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify: X
14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12) / College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant
16b. Kind of Business/Industry: Construction

17. Fether's Name (First, Middle, Last): Neil McBrearty
18. Mother's Neme (First, Middle, Maiden Surname): Anne Rudden

19a. Informent's Neme/Reletionship (Type, Print): John T. O'Connor / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17605 Prince David Dr., Olney, MD 20832

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removef from State 4☐ Donelion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Gate of Heaven Cemetery
Dete: 12/2/99
20c. Location - City or Town, Stete: Silver Spring, MD

21. Signature of Funeral Service Licansee: Robert E Ramsey
22. Neme end Address of Facility: Francis J. Collins Funeral Home, Inc 500 University Blvd, W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. (Approximete Intervel Between Onset and Deeth)

Immediate Cause (Finel diseese or condition resulting in death)
a. Hypertensive Heart Disease
Due to (or as e consequence of):
b. Senile Dementia.
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Last
Due to (or as a consequence of):
c. Diabetics Mellitus.
Due to (or as a consequence of):
d. Septicaemia.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated. 2☐ Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, death occurred at the time, date and pleca, end due to the cause(s) end manner steted.

29b. Signature and title of certifier: Thomas V. Joseph
29c. License number: D0047330
29d. Date signed (Month, Day, Year): 12/1/99

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): Thomas V. Joseph, M.D. 50 W. Edmonston Dr. Rockville. MD 20852

State Registrar

31. Dete filed (Month, Day, Year): DEC 02 1999
32. Registrar's Signature: Lenora G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39710

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): June Terese Olvey
2. Date of Death (Month, Day, Year): November 25, 1999
3. Time of Death: 6:55 AM
4a. Facility Name (If not institution, give street and number): Montgomery Village Care & Rehabilitation
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-42-7630
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 14, 1932
9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2101 Dayton Street
10f. Zip Code: 20902
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Charity Organization

17. Father's Name (First, Middle, Last): John William Shea
18. Mother's Name (First, Middle, Maiden Surname): Mary Agnus Dempsey

19a. Informant's Name/Relationship (Type, Print): Kathleen Marie Olvey (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 958 Windbrooke Drive, Gaithersburg, MD 20879

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: 11-27-99
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: ▶ Carol a Dehn
22. Name and Address of Facility: Rapp Funeral & Cremation Services, Stephen D. Lohrmann, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert failure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediete Cause (Finel disease or condition resulting in deeth): a. Hepatic Decompensation — 1 year

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest

b. Due to (or es e consequence of):

c. Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or Investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture end title of certifier: ▶ Myron L. Lenkin
29c. License number: D06674
29d. Date signed (Month, Day, Year): 11/26/99

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): MYRON L. LENKIN MD — 2309 SHOREFIELD RD WHEATON MD 20902

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999
32. Registrar's Signeture: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the deeth certificate be executed within 24 hours after deeth.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39711

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Markus La'Wrence Picott

2. Date of Death: Month 11 Day 25 Year 99

3. Time of Death: 5:45 pm

4a. Facility Name *(If not institution, give street and number)*: 3801 F. Veteran Court

4b. City, Town, or Location of Death: Aberdeen P.G.

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 213-11 7758

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 29 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 12/15/69

9. Birthplace *(State or Foreign Country)*: Wash. D.C.

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Aberdeen Proving Grounds

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 3801 F.. Veteran Court

10f. Zip Code: 21005

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Draftsman

16b. Kind of Business/Industry: W.S.S.C.

17. Fethar's Name *(First, Middle, Last)*: Larry Picott

18. Mothar's Name *(First, Middle, Maiden Surname)*: Doreatha Taliaferro

19a. Informant's Name/Relationship *(Type, Print)*: Larry Picott/father

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11103 Lenox Dr.Upper Marlboro,MD.20774

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Resurrection Cem.

Date: 12/1/99

20c. Location - City or Town, State: Clinton,MD

21. Signature of Funeral Servica Licensee: Bruce Edwards

22. Name and Address of Facility: Hodges and Edwards 3910 Silver Hill RD.Suitland,Md.20746

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter tha moda of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximata Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Leukemia, Acute Lymphoblastic — 24 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causa of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Ware autopsy findings available prior to completion of causa of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examinar? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Bryant

29c. License number: JA 0101049358

29d. Date signed *(Month, Day, Year)*: 12/2/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Bryant 6500 GA. Ave. N.W. Wash. D.C. 20012

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 03 1999

32. Registrar's Signature

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39712

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lillie Mae Patterson
2. Date of Death Month Day Year: November 30, 1999
3. Time of Death: 8:40AM
4a. Facility Name *(If not institution, give street and number)*: 6306 Gabriel Street
4b. City, Town, or Location of Death: Bowie
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 048-20-2838
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 28, 1917
9. Birthplace *(State or Foreign Country)*: Georgia

Usual Residence of Decedent

10a. State: MD.
10b. County: Prince Georges
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6306 Gabriel Street
10f. Zip Code: 20720
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Harry Goodman Walker Sr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Pearl Alice Baker

19a. Informant's Name/Relationship *(Type, Print)*: daughter Gloria Patterson-Lucas
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6306 Gabriel Street Bowie, Maryland 20720

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lee Memorial Park
Date: 12/6/99
20c. Location - City or Town, State: Ft. Myers, Florida

21. Signature of Funeral Service Licensee: Bruce Edwards
22. Name and Address of Facility: Hodges & Edwards F.H. 3910 Silver Hill RD. Suitland, MD. 20746

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hypoxia — 5 minutes
Due to (or as a consequence of):
b. Myocardial Infarction — 1 hour
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Diabetes Mellitus — 20 years
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: DE 3318
29d. Date signed *(Month, Day, Year)*: 12-03-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. John Kim — JOHN KIM MD 1050 W PERIMETER RD ANDREWS AFB, MD 20762

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 08 1999
32. Registrar's Signature: [signature]

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

DEC 03 1993

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39713

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN PHILLIPS, JR.

2. Date of Death: Month 11 Day 22 Yaar 99

3. Time of Death: 3:40 am

4a. Facility Name (If not institution, giva straat and number): WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: TAKOMA PARK

4c. County of Daath: MONTGOMERY

Funeral Director

5. Social Security Number: 251-28-1505

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 76 Yrs. If Under 1 Yaar: Months / Days. If Undar 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Yaar): December 31, 1922

9. Birthplace (Stata or Foraign Country): South Carolina

Usual Rasidanca of Dacadent

10a. Stata: Maryland

10b. County: Prince George's

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1 [X] Yas 2 [ ] No

10a. Straat and Number: 3607 Gallatin Street, #421

10f. Zip Coda: 20782

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1 [ ] Navar Married 2 [ ] Married 3 [X] Widowad 4 [ ] Divorced

12. Was Decadant Evar in U.S. Armed Forcas? 1 [ ] Yes 2 [X] No If Yes, Giva Yaar or Dates:

13. Was Dacadant of Hispanic Origin? (Spacify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:

14. Raca - American Indian, Black, White, atc. Specify: Black

15. Decadent's Education (Specify only highast grada completed): Elamentary/Secondary (0-12): 8th; College (1-4or 5+):

16a. Decadent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired): Security Guard

16b. Kind of Businass/Industry: Private

17. Fathar's Name (First, Middla, Last): John Phillips, Sr.

18. Mothar's Nama (First, Middle, Maidan Surnama): (Unknown)

19a. Informant's Nama/Relationship (Typa, Print): Denise Phillips/Daughter

19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda): 933 South Grandee, #C, Compton, California 90220

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Spacify)

20b. Placa of Disposition (Nama of camatary, cramatory or othar placa): Forest Hills Cemetery

Data: 12/01/1999

20c. Location - City or Town, Stata: Clinton, Maryland

21. Signature of Funaral Sarvice Licansaa: [signature]

22. Name and Addrass of Facility: J.B. JENKINS FUNERAL HOME, 7474 Landover Road, Landover, Maryland 20785

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not enter tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach line.

Approximate Interval Batwaan Onsat and Daath

Immediata Causa (Final disease or condition resulting in death)

a. End Stage Renal Failure

Dua to (or as a consequence of):

Sequantially list conditions, if any, laading to immediata causa. Entar Underlying Causa (Disaasa or injury that initiatad avants resulting in daath) Last

b. Severe Hypertension

Due to (or as a consaquanca of):

c.

Due to (or as a consequanca of):

d.

Part II. **Othar significant conditiona** contributing to death but not rasulting in tha underlying causa given in Part I.

23b. Did tobacco usa contributa to the cauaa of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings available prior to complation of causa of death? 1 [ ] Yas 2 [ ] No

25. Was case referred to medical examinar? 1 [ ] Yas 2 [X] No

26. Placa of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatiant 3 [ ] DOA; Othar: 4 [ ] Nursing Homa 5 [ ] Rasidance 6 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding investigation 6 [ ] Could not be determinad

28a. Data of Injury (Month, Day Yaar)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurrad

28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Spacify)

28f. Location (Streat and Numbar or Rural Routa Numbar, City or Town, Stata)

29a. Certifiar (Check only one): 1 [ ] **Certifying Physician:** To the bast of my knowledga, death occurrad at the time, data and placa, and dua to tha cause(s) and manner as stated. 2 [ ] **Medical Examinar:** On tha basis of examination and/or invastigation, in my opinion, daath occurrad at the tima, data and placa, and dua to the cause(s) and mannar statad.

29b. Signatura and title of certifiar: [signature]

29c. Licansa numbar: D 20129

29d. Data signed (Month, Day, Yaar): 11/23/99

30. Nama and addrass of parson who complatad cause of death (Item 23a) (Type, Print): ACHANKUNJU. A - CHACKO, 7610 Carroll Ave. 390 Takoma Park. MD. 20912

State Registrar

31. Data filad (Month, Day, Yaar): DEC 01 1999

32. Registrar's Signatura: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DEC 01 1959

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39714

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alvin Page

2. Date of Death — Month: 11 Day: 24 Year: 99

3. Time of Death: 1245pm

4e. Facility Name (If not institution, give street and number): Prince George's Hosp. Center

4b. City, Town, or Location of Death: P G Hosp Center

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-68-6090

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 50 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 6, 1949

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10e. State: MD

10b. County: Prince Georges

10c. City, Town or Location: Landover Hills

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 7529 Buchanan St. #155

10f. Zip Code: 20784

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Disabled

16b. Kind of Business/Industry:

17. Father's Name (First, Middle, Last): William Page

18. Mother's Name (First, Middle, Maiden Surname): Willie Booker

19a. Informant's Name/Relationship (Type, Print): Vivian Gassaway/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7529 Buchanan St. #155 Landover Hills, MD, 20784

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Memorial Park

Date: 11-30

20c. Location - City or Town, State: Landover, MD.

21. Signature of Funeral Service Licensee: Jr P. Marshall

22. Name and Address of Facility: Marshall's Funeral Home, Inc. 4308 Suitland Rd. Suitland, MD. 20746

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Acute exacerbation of COPD

Due to (or as a consequence of):
b. End Stage lung disease

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Staphylococcal Sepsis

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Long history of Smoking

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) — Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D 43662

29d. Date signed (Month, Day, Year): 11-26-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William J. Boyce, 3001 Hospital Drive, Cheverly MD 20785

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(2)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39715

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Paulina Peavy
2. Date of Death Month Day Year: 11 - 18 - 99
3. Time of Death: 240 p.m.
4a. Facility Name (If not Institution, give street and number): Mariner of Bethesda
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 569-26-7625
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 98 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8/24/1901
9. Birthplace (State or Foreign Country): Colorado

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7017 Richard Dr.
10f. Zip Code: 20817
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Art Teacher
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Earl Cassius White
18. Mother's Name (First, Middle, Maiden Surname): Bertha Pederson

19a. Informant's Name/Relationship (Type, Print): Bradley Peavy/ Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7017 Richard Dr. Bethesda, MD 20817

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): National Crematory
Date: Nov.27,
20c. Location - City or Town, State: Falls Church, VA

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Affordable Funeral Service Merrifield, VA

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Cerebrovascular Accident — Sudden

Due to (or as a consequence of):
Hypertension — 10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
Alzheimers Dementia — 5 years
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D20065
29d. Date signed (Month, Day, Year): 11-23-1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): EVA MORELL 6000 EXECUTIVE BLVD, ROCKVILLE MD 20852

(5)

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

99-7178-027
CJ
Unknown 99-297
Susan Polhamus

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND #@#&27-28f PER M.E.O. G778 12-20-99 J.A. **Certificate of Death**

Reg. No. 99 39716

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Susan Polhamus

2. Date of Death: Month November, Day 30, Year 1999

3. Time of Death: 11:20 AM.

4a. Facility Name (If not institution, give street and number): Parking Lot / 3004 North Ridge Road

4b. City, Town, or Location of Death: Ellicott City

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 592 42 1258

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 27 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 25, 1972

9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: Florida

10b. County: Palm Beach

10c. City, Town or Location: Baca Raton

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 20952 Delagado Terrace

10f. Zip Code: 33433

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12; College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesperson

16b. Kind of Business/Industry: Eyeware

17. Father's Name (First, Middle, Last): Richard Polhamus

18. Mother's Name (First, Middle, Maiden Surname): Jill Kilgore

19a. Informent's Name/Relationship (Type, Print): Richard Polhamus Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20952 Delagado Terrace Baca Raton Florida 33433

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): The Huntt Crematory | Date: Dec. 8, 1999

20c. Location - City or Town, State: Waldorf Maryland

21. Signature of Funeral Service Licensee: Michael L. Bile

22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on aach line. | Approximate Interval Between Onsat end Death

Immediate Cause (Final disease or condition resulting in death): a. CARBON MONOXIDE INTOXICATION;NARCOTIC INTOXICATION

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☑ Yes 2☐ No

24b. Were eutopsy findings eveileble prior to completion of cause of daath? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Scene

27. Manner of Death: 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Deta of Injury (Month, Day Year): FOUND 11-30-99

28b. Time of Injury: FOUND 10:55 A M

28c. Injury at Work? 1☐ Yas 2☒ No

28d. Dascribe how injury occurred: INHALED EXHAUST FUMES FROM CAR

28e. Piece of Injury - At home, farm, street, fectory, office building, atc. (Specify): FOUND:PARKING LOT IN VEHICLE

28f. Location (Street and Number or Rural Route Number, City or Town, State): HEARTLANDS 3004 N. RIDGE ROAD ELLICOTT CITY, MD.

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end piece, end dua to tha ceuse(s) end manner as stated. 2☒ **Medical Examiner**: On the basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and place, and dua to tha causa(s) and manner stated.

29b. Signature and title of certifier: Wayne Buckhall

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): December 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARYANN B. KOREN 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 10 1999

32. Registrar's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DEC 10 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39717

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John Royer PERROTT
2. Date of Death Month / Day / Year: December 7th 1999
3. Time of Death: 6:10 am
4a. Facility Name *(If not institution, give street and number)*: Western Maryland Hospital Center
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-09-8987
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 28 1912
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1041 Benjamin Place
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machine Operator
16b. Kind of Business/Industry: Sandblasting

17. Father's Name *(First, Middle, Last)*: Jacob Perrott
18. Mother's Name *(First, Middle, Maiden Surname)*: Effie Bartles

19a. Informant's Name/Relationship *(Type, Print)*: John Richard Perrott - Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13751 Barnhart Road Clear Spring, Maryland 21722

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rest Haven Cemetery — Date: 12/9/99
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott D. Minnich
22. Name and Address of Facility: Minnich Funeral Home 615 E. Wilson Blvd. Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — 1 Week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Heart Failure

Due to (or as a consequence of):
c. Atrial Fibrillation

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Parkinson's Disease

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D41112
29d. Date signed *(Month, Day, Year)*: December 7, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Ian Newbold 1500 Pennsylvania Ave, Hagerstown, MD 21742

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 08 1999
32. Registrar's Signature: Denise G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39718

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hellen Louise Paul

2. Date of Death (Month, Day, Year): Nov. 26 1999

3. Time of Death: 10:30 PM

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 219-20-3797

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 26, 1924

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Williamsport

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 111 West Potomac Street

10f. Zip Code: 21795

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Glen Whittington

18. Mother's Name (First, Middle, Maiden Surname): Edna Pearl Mowen

19a. Informant's Name/Relationship (Type, Print): Lisa Vandruff

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 30 North Vermont St. Williamsport, Maryland 21795

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Greenlawn Memorial Park

Date: 11-29-99

20c. Location - City or Town, State: Williamsport, Maryland

21. Signature of Funeral Service Licensee: Burl E Osborne

22. Name and Address of Facility: Osborne Funeral Home 425 South Conococheague St. Williamsport, Maryland 21795

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — 2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- Renal Failure with oedema
- Hepatic Failure
- Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year): NA

28b. Time of Injury: NA M

28c. Injury at Work? 1☐ Yes 2☐ No: NA

28d. Describe how injury occurred: NA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): NA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gloria F. Pura, MD

29c. License number: D19824

29d. Date signed (Month, Day, Year): Nov. 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GLORIA F. PURA 366 Mill St. Hagerstown MD 21740

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999

32. Registrar's Signature: Penny G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Hellen Louise Paul

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39719

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Catherine Palladino

2. Date of Death: Month: November Day: 25 Year: 1999

3. Time of Death: 0052

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214 09 9267

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months: Days:

If Under 24 Hrs.: Hours: Min.:

8. Date of Birth (Month, Day, Year): September 11, 1913

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedant

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11510 Englewood Road

10f. Zip Code: 21740

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): bookkeeper

16b. Kind of Business/Industry: Paint & Glass

17. Father's Name (First, Middle, Last): Fred Leon Rudy

18. Mother's Name (First, Middle, Maiden Surname): Erma Catherine Miller

19a. Informant's Name/Relationship (Type, Print): Robert J. Palladino Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11510 Englewood Rd. Hagerstown, Md. 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Rest Haven Cemetery

Date: 11/27/99

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Gerald N. Minnich

22. Name and Address of Facility: Gerald N. Minnich Funeral Home, 305 N. Potomac St. Hagerstown, Maryland

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure — 7 days

Due to (or as a consequence of):

b. Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Emphysema
Cachexia
Pneumothorax

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Francisco Andrade

29c. License number: D27898

29d. Date signed (Month, Day, Year): 11/25/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANCISCO L. ANDRADE 350 MILL ST. HAGERSTOWN MARYLAND 21740

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Palladino, Helen C.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39720

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nettie Faye Parks
2. Date of Death: Month 12 Day 2 Year 99
3. Time of Death: 9:45AM
4a. Facility Name (If not institution, give street and number): Frederick Health Care Center
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 227-16-6048
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Feb 1 1922
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Frederick
10c. City, Town or Location: Knoxville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3103 Addition Avenue
10f. Zip Code: 21758
10g. Citizen of Whet Country?: USA

11. Marital Stetus: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bteck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 6; College (1-4or 5+):
16a. Decedent's Usual Occupetton (Give kind of work done during most of working life. DO NOT use retired): Seamstress
16b. Kind of Business/Industry: Hartz Company Frederick, MD

17. Father's Name (First, Middle, Last): Lester Jones
18. Mother's Name (First, Middle, Maiden Surname): Jettie Crouse

19a. Informent's Name/Reletionship (Type, Print): Helen Anne Hopwood, Daughter
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 403 East Main Street, Burkittsville, MD 21718

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removet from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Union Cemetery
Dete: 12/5/99
20c. Location - City or Town, State: Burkittsville, MD

21. Signature of Funeral Service Licensee: Barbara A. Williams, Owner
22. Name and Address of Facility: John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 21716

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset and Deeth

Immediete Ceuse (Final disease or condition resulting in death)
e. acute pulmonary edema — hours
Due to (or es a consequence of):
b. acute myocardial infarction — hours

Sequentiatly list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.
Alzheimer's type dementia

23b. Dfd tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy tindings evelleble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medicat exeminer? 1☐ Yes 2☑ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowtedge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner es steted.
2☐ **Medicat Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) and manner stated.

29b. Signeture and title of certifier: Kathleen W. Stern MD
29c. License number: D32073
29d. Date signed (Month, Day, Year): 12/3/99

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Kathleen W Stern MD, 610 Ninth Ave, Brunswick, Md. 21716

State Registrar

31. Date filed (Month, Dey, Yeer): DEC 06 1999
32. Registrer's Signeture: G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39721

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JUM SUK PARK
2. Date of Death: Month NOVEMBER Day 28 Year 1999
3. Time of Death: 10:40 P.M.
4a. Facility Name (If not institution, give street and number): SUBURBAN HOSPITAL
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 214-92-1259
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 93 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 22, 1906
9. Birthplace (State or Foreign Country): KOREA

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: OLNEY
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 18166 HEADWATERS DRIVE
10f. Zip Code: 20832
10g. Citizen of What Country?: UNITED STATES OF AMERICA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: KOREAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLERGY
16b. Kind of Business/Industry: MINISTRY

17. Father's Name (First, Middle, Last): HAN KYUNG PARK
18. Mother's Name (First, Middle, Maiden Surname): UNOBTAINABLE

19a. Informant's Name/Relationship (Type, Print): CHONG H. PARK/SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18166 HEADWATERS DRIVE OLNEY, MARYLAND 20832

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): NORBECK MEMORIAL PARK
Date: 12/1/99
20c. Location - City or Town, State: OLNEY, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. SEPSIS — HOURS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end piece, and due to the cause(s) end menner steted.

29b. Signature and title of certifier: [signature] Catherine F. McCoy MD
29c. License number: D35293
29d. Date signed (Month, Day, Year): 11-28-99

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): CATHERINE MCCOY, M.D. 8600 OLD GEORGETOWN RD. BETHESDA, MARYLAND 20814

State Registrar

31. Dete filed (Month, Dey, Year): DEC 02 1999
32. Registrer's Signeture: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020
Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

5 RELEASED BY M.E.

JUM SUK PARK 11-28-99 10:40 pm

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39722

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day	Year	3. Time of Death
KITTY	PELTZ	11	30	99	10:27 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SUBURBAN HOSPITAL	BETHESDA	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-48-1852	1☐ M 2☒ F	98 Yrs.					3/17/1901	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	MONTGOMERY	ROCKVILLE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
6121 MONTROSE ROAD	20852	USA

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Bleck, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeor or Detes:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12		HOMEMAKER	OWN HOME

17. Fether's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Sumeme)
(UNKNOWN) GORDON	EMMA (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)	19b. Meiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
KENNETH PELTZ/SON	11005 BALANTRE LANE POTOMAC, MARYLAND 20854

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, State
1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)	KING DAVID MEMORIAL GARDENS	12/2/99	FALLS CHURCH, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Donald C. Stottlemyer	DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

b

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart 1ailure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. CONGESTIVE HEART FAILURE	
	Due to (or es a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or es e consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did 1obacco use contribute 1o the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed?	24b. Were autopsy findings aveilable prior to completion of cause of deeth?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medicat examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)			28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)	
1☒	**Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted.
2☐	**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the ceuse(s) and manner steted.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Kevin Moore MD	D50628	12/1/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kevin Moore MD 8600 old georgetown RD 20814, Bethesda Mayla

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Pelz, Kitty 11/30/99 2827

3

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 02 1999	G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

RKD

99-7071-031

ROBERTA PENNACCHINI AMEND#23&27 PER M.E.O. G778 12-28-99 J.A.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39723

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Roberta A. Pennacchini

2. Date of Death (Month, Day, Year): NOVEMBER 26, 1999

3. Time of Death: 10:39A.M.

4e. Facility Name (If not institution, give street and number): MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death: OLNEY

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 212-64-6367

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 46 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr 15, 1953

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 3701 International Drive Apt 211

10f. Zip Code: 20906

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student

16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Eugene S. Pennacchini

18. Mother's Name (First, Middle, Maiden Surname): Sophie Winiarczuk

19a. Informant's Name/Relationship (Type, Print): Eugene S. Pennacchini/ Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3701 International Drive, Apt 211, Silver Spring, MD 20906

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetary, crematory or other place): Gate of Heaven Cemetery

Date: Nov 30 1999

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Eric S Scerbo

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE PANCREATITIS AND BOWEL NECROSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): NOVEMBER 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RKD

99-7047-045

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

· TAMMY

PHILLIPSON Amend #5,17, 12/1/99,BMW,Montg.Co.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 39724

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Tammetha Joyce Philipson	NOVEMBER 24, 1999	1:56P.M.

4a Facility Neme (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-78-~~3654~~ 3751	1☐ M 2☒ F	31 Yrs.			Dec. 14, 1967	Maryland

Usuel Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Worcester	Ocean City	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1208 Baltimore Avenue #2	21842	United States

11. Maritel Stetus	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Bleck, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Dates:	1☐ Yes 2☒ No *Specify:*	*Specify:* White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elemantary/Secondery (0-12)	College (1-4or 5+)		
12		Receptionist	Rental Real Estate

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Randall Ira Mullins ~~Randall Mullins~~	Donna Irene Clark

19e. Informant's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Randall Mullins (Father)	3324 Lowell Lane, Ijamsville, MD 21754

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, cremetory or other place)	Date	20c. Location - City or Town, State
1☐ Buriel 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other (Specify)	Metropolitan Crematory	11/30/99	Alexandria, Virginia

21. Signeture of Funerel Service Licensee: Robert A. DeVol

22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failura. List only one cause on aach line.

Approximata Interval Between Onset and Death

Immediate Cause (Final disaase or condition resulting in daeth): a. MULTIPLE INJURIES

Due to (or as a consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Entar Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest:

b.

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other aignificant conditiona contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Manner of Death: 1☐ Naturel 2☒ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigetion 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year): 11-24-99

28b. Time of Injury: 1030P M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: DRIVER OF PICKUP WENT OFF ROAD AND EJECTED

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify): ROADWAY

28f. Location (Street and Number or Rural Route Number, City or Town, Stete): US50 WORCESTER CO MD

29a. Certifier (Check only one): 1☐ Certifying Physician: To tha best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On tha basis of examination and/or investigation, in my opinion, death occurred at the time, data and piece, end due to the cause(s) and menner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Wayne Preskill MD	O.C.M.E.	NOVEMBER 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARYANNE D. KOROL, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrar's Signature
NOV 30 1999	Jenna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5 (7)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39725

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ARTHUR GORDON PHILLIPS
2. Date of Death: Month NOVEMBER Day 26 Year 1999
3. Time of Death: 1345
4e. Facility Name *(If not institution, give street and number)*: SUBURBAN HOSPITAL
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 216-06-1104
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 16 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: AUG. 24, 1983
9. Birthplace *(State or Foreign Country)*: WASH. D.C.

Usual Residence of Decedent

10a. State: Md.
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 5113 Wapakoneta Road
10f. Zip Code: 20816
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Student
16b. Kind of Business/Industry: Student

17. Father's Name *(First, Middle, Last)*: Gary Dale Phillips
18. Mother's Name *(First, Middle, Maiden Surname)*: Cheryl Alderdice

19e. Informant's Name/Relationship *(Type, Print)*: Gary Phillips
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5113 Wapakoneta Road, Bethesda, Md. 20816

20e. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: National Crematory
Date: 12/2/99
20c. Location - City or Town, State: Falls Church, Va.

21. Signature of Funeral Service Licensee: Thomas E. Hombaker
22. Name and Address of Facility: Joseph Gawler's sons, Inc. 5130 Wisc. Ave. NW. Washington, D.C. 20016

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert tailure. List only one cause on eech line.

Approximate Intervel Between Onset end Death

Immediete Cause (Final disease or condition resulting in deeth)
e. INTRACEREBRAL HEMORRHAGE

Due to (or es e consequence of):
b. MASSIVE CONTUSION OF BRAIN

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest

Due to (or es a consequence of):
c. FRACTURE OF SKULL

Due to (or as e consequence of):
d. AUTO COLLISION

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
INTERNAL INJURIES OF THORAX AND ABDOMEN

23b. Did tobacco use contribute to the ceuse of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Wes an eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings aveileble prior to completion of ceuse of deeth? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Deeth *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpetient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Deeth: 1 [ ] Neturel 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28e. Dete of Injury *(Month, Dey Year)*: NOVEMBER 26, 1999
28b. Time of Injury: 1245 PM
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: PASSENGER IN JEEP THAT HIT A POLE.
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: STREET
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*: 5000 BLOCK OF SANGAMORE / BETHESDA / MD

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) end manner es stated. 2 [X] **Medical Examiner:** On the besis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) and menner stated.

29b. Signature and title of certifier: M.D. (OME)
29c. License number: 015236
29d. Dete signed *(Month, Dey, Year)*: NOVEMBER 26, 1999

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): CARL I. MARGOLIS, MD 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: DEC 03 1999
32. Registrer's Signature: G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires thet the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

To Be Completed by Funeral Director

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39726

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anna Poney
2. Date of Death: Month Nov Day 28 Year 1999
3. Time of Death: 1854
4a. Facility Name (If not institution, give street and number): 2003 Georgian Way
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 217-94-1112
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 34 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 22, 1965
9. Birthplace (State or Foreign Country): DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2003 Georgian Way #4
10f. Zip Code: 20902
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales Clerk
16b. Kind of Business/Industry: Retail

17. Father's Name (First, Middle, Last): Gabriel Poney
18. Mother's Name (First, Middle, Maiden Surname): Arletta D. Mabon

19a. Informant's Name/Relationship (Type, Print): Arletta D. Poney / Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3121-3 University Blvd., West, Kensington, MD 20895

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Gate of Heaven Cemetery — Date: Dec 2 1999
20c. Location - City or Town, Stele: Silver Spring, MD

21. Signature of Funeral Service Licensee: Eric S. Scerbo
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. AIDS — DME

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, feclory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated. 2☒ **Medical Examiner:** On the basis of examination end/or investigation, In my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature end title of certifier: Ira N Brecher MD DME
29c. License number: D00428
29d. Date signed (Month, Day, Year): Nov 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): IRA N BRECHER, MD DME 2101 Medical Park Dr Silver Spring md 20902

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 9558.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39727

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Essie Beatrice Ricker
2. Date of Death (Month, Day, Year): November 29 1999
3. Time of Death: 6:00 PM
4a. Facility Name (If not institution, give street and number): Deaton Specialty Hospital and Home
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 212 20 3064
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 12,1914
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 305 E. 28th St.
10f. Zip Code: 21218
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Peter Johns
18. Mother's Name (First, Middle, Maiden Surname): Dena Branham

19a. Informant's Name/Relationship (Type, Print): Albert R. Johns / Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2955 Edgewood Ave., Baltimore, MD 21234

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory Inc. | Date: 12/4/99
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Stephen D. Lohrmann
22. Name and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Stroke	1 day
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Atherosclerosis Vascular Disease	10 Years
Due to (or as a consequence of):		
c.	Hypertension	15 Years
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D38675
29d. Date signed (Month, Day, Year): 11 / 30 / 99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOEL MESHULAM 1147 S HANOVER ST BALTIMORE MD 21230

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DEC 0 8 1988

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39728

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donna Rowland
2. Date of Death: Month December Day 1 Year 1999
3. Time of Death: 4:20 PM
4a. Facility Name (If not institution, give street and number): Deaton Specialty Hospital and Home
4b. City, Town, or Location of Death: Baltmore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 215 24 7394
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 71 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 21, 1928
9. Birthplace (State or Foreign Country): Michigan

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3905 W. Strathmore Ave.
10f. Zip Code: 21215
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12; College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Real Estate Agent
16b. Kind of Business/Industry: Real Estate

17. Fether's Neme (First, Middle, Last): Harry George Wentworth
18. Mother's Name (First, Middle, Maiden Surname): Martha May Lowman

19a. Informent's Neme/Relationship (Type, Print): Margaret Zerzvica / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 224 E. Center Ave., Lake Bluff, IL 60044

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory Inc.
Date: 12/4/99
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Stephen D. Lohrmann
22. Neme and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediete Cause (Finel diseese or condition resulting in deeth): e. Cancer of Lung with Brain Metastasis — 7 weeks

Due to (or es e consequence of): b. Diabetes Mellitus

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: Cmehuta MD
29c. License number: D34974
29d. Date signed (Month, Day, Year): December 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARU MEHTA, MD. 8775 cloud leap ct # 224, Columbia, MD 21045

State Registrar

31. Dete filed (Month, Day, Year): DEC 03 1999
32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

DEC 0 3 1999

99-7094-033
JAD

Ray D. Deanre

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39729

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
DeAndre' Dejuan Ray	November 27, 1999	15:45

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Prince Georges Hospital Center	Cheverly	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-04-4888	1☐M 2☐F X	18 Yrs.			Apr.24,1981	Wash.,D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
		Washington,D.C.	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1412 E Street S.E.	20019	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Musician	Self Employed

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Rickey J'don Ray	Cynthia Lee Jones

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Cynthia Lee Jones (Mother)	1412 E.Street S.E.,Wash.,D.C.

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Forest Hills, Cemetery	12-4-99	Clinton, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Phillip Bell	Phillip Bell Funeral Service 4902 Stan Haven Rd.,Temple Hills,Md.20748

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Multiple Gunshot Wounds

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
☒Yes 2☐No	Hospital: 1☐Inpatient ☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☒Homicide 5☐Pending investigation 6☐Could not be determined	11-27-99	15 15 M	1☐Yes 2☒No	Subject Shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Street in car	1400 D. St SE Washington DC

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	O.C.M.E.	November 28, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 03 1999	

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

DEC 0 3 1998

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39730

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Bryan Rosenberg

2. Date of Death (Month, Day, Year): November 28, 1999

3. Time of Death: 4:10 PM

4a. Facility Name (If not institution, give street and number): Doctor's Community Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-66-5452

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 48 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 1, 1951

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Ft. Washington

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 12205 Hollybank Drive

10f. Zip Code: 20744

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Attorney

16b. Kind of Business/Industry: Self Employed

17. Father's Name (First, Middle, Last): Eugene Rosenberg

18. Mother's Name (First, Middle, Maiden Surname): Juanita Carro

19a. Informant's Name/Relationship (Type, Print): Raymond Ross Rosenberg (brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 35 Wilelinor Drive, Edgewater, Maryland 21037

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory

Date: 11-29-99

20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Carol A Dehm

22. Name and Address of Facility: Rapp Funeral & Cremation Services, Stephen D. Lohrmann, P.A. 933 Gist Avenue, Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Septic Shock — 48 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Acute Hepatocellular Necrosis — 5 days

Due to (or as a consequence of):

c. Lymphoma — 8 months

Due to (or as a consequence of):

d. Acquired Immunodeficiency Syndrome — 7 years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Acute Renal Failure

Coagulopathy

Anemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Divya Verma Physician

29c. License number: D52298

29d. Date signed (Month, Day, Year): November 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Divya Verma, M.D., 7525 Greenway Center Drive, Suite 202, Greenbelt, MD 20770

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39731

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Concettina Edith Ricchiuti

2. Date of Death (Month, Day, Year): November 23, 1999

3. Time of Death: 7:30 am

4a. Facility Name (If not institution, give street and number): Magnolia Gardens Nursing Home

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 214-42-4470

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 21, 1918

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Riverdale

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6219 Tuckerman Street

10f. Zip Code: 20737

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Nicholas Cordone

18. Mother's Name (First, Middle, Maiden Surname): Maria Mevisani

19a. Informant's Name/Relationship (Type, Print): Mary R. DeRight - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4250 Tupelo Court, Port Republic, MD 20676

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery | Date: 11/26/99

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: Claudette J. Dasch

22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Cardiomyopathy — Months

Due to (or as a consequence of):

b. Athero sclerotic Heart Disease — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Renal Insufficiency

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: St

29c. License number: D37934

29d. Date signed (Month, Day, Year): November 23, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephanie Trifoglio, M.D. 7500 Greenway Center Drive #430, Greenbelt, MD 20770

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39732

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Wilburn Essie RHOTON
2. Date of Death (Month, Day, Year): December 7, 1999
3. Time of Death: 5:05 AM
4a. Facility Name (If not institution, give street and number): 15336 Clear Spring Rd.
4b. City, Town, or Location of Death: Williamsport
4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 220-26-5793
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 25, 1928
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. Stete: MD
10b. County: Washington
10c. City, Town or Location: Williamsport
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 15336 Clear Spring Rd.
10f. Zip Code: 21795
10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+): 0
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer
16b. Kind of Business/Industry: Agriculture

17. Father's Name (First, Middle, Last): Jeremiah Marr Rhoton
18. Mother's Neme (First, Middle, Maiden Surname): Ruby Lee Marcum

19a. Informent's Neme/Relattonship (Type, Print): Steven L. Rhoton (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15336 Clear Spring Rd. Williamsport, MD 21795

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenlawn Memorial Park | Date: Dec. 9, 1999
20c. Location - City or Town, State: Williamsport, MD 21795

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: OSBORNE FUNERAL HOME P.O.Box # 348 Williamsport, MD 21795

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line.

		Approximete Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting tn death)	e. MALIGNANT PLEURAL EFFUSION	2 MONTHS
Due to (or es e consequence of):		
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that Initiated events resulting in death) Last	b.	
Due to (or as e consequence of):		
	c.	
Due to (or as e consequence of):		
	d.	

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert t.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted. 2☐ **Medicat Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: Amy Ami MD
29c. License number: D0033119
29d. Dete signed (Month, Day, Year): 12/7/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AMNLEY SRI, MD · VA HOSPITAL, MARTINSBURG, W.V. 25401

State Registrar

31. Date filed (Month, Day, Year): DEC 07 1999
32. Registrar's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth end Mental Hygiene.
Important: If item 27 le marked other than 'natural', or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Divlsion of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39733

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ada Mae Ralston

2. Date of Death (Month, Day, Year): NOVEMBER 25, 1999

3. Time of Death: 7:00PM

4a. Facility Name (If not Institution, give street and number): RAVENWOOD LUTHERAN VILLAGE

4b. City, Town, or Location of Death: HAGERSTOWN

4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 189-42-1271

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jun.18,1907

9. Birthplace (State or Foreign Country): WV.

Usual Residence of Decedent

10a. State: Md.

10b. County: Washington

10c. City, Town or Location: Clear Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 15009 Hicksville Rd.

10f. Zip Code: 21722

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Beautician

16b. Kind of Business/Industry: Cosmetology

17. Father's Name (First, Middle, Last): Charles A Dudley

18. Mother's Name (First, Middle, Maiden Surname): Nettie Leach

19a. Informant's Name/Reletionship (Type, Print): Noel D.Ralston/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15009 Hicksville Rd.,ClearSpring,Md.21722

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Plesant Hill Cemetery | Date: 11/29

20c. Location - City or Town, State: Morgantown,WV.

21. Signature of Funeral Service Licensee: Fred C. Burner MBIE

22. Name and Address of Facility: Burner Trade Services 1037 Dual Place Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Finel disease or condition resulting in death)
e. CARDIOPULMONARY ARREST — INSTANT

Due to (or es a consequence of):
b. ARTERIOSCLEROTIC HEART DISEASE — MANY YEARS

Sequentielly list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA OF ALZHEIMERS TYPE

DEHYDRATION AND INANITION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Edson B. Moody MD

29c. License number: D07857

29d. Date signed (Month, Day, Year): 11/29/99

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print): DR. EDSON MOODY MD. 1190 MT. AETNA RD., HAGERSTOWN, MD. 21740

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999

32. Registrar's Signature: Linda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Ada Mae RALSTON

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39734

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLOTTE LOUISE RIDENOUR

2. Date of Death: Month Nov, Day 24, Year 1999

3. Time of Death: 0650

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 236-50-1173

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): March 21, 1933

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13804 Pennsylvania Avenue

10f. Zip Code: 21742

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 9 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager

16b. Kind of Business/Industry: Dry Cleaners

17. Father's Name (First, Middle, Last): Willis Powell Van Metre

18. Mother's Name (First, Middle, Maiden Surname): Edna Grace Geneva Snyder

19a. Informant's Name/Relationship (Type, Print): William D. Ridenour

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13804 Pennsylvania Avenue, Hagerstown, Md. 21742

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematorium | Date: 11-24-99

20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: R. Noel Brady

22. Name and Address of Facility: Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart teilure. List only one cause on each fine.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac arrythmia — Minutes

Due to (or es a consequence of):
b. Hypertension — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicaf examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D21457

29d. Date signed (Month, Day, Year): 11/24/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ABDUL WAHEED, MD - 12821 OAK HILL AVE. HAGERSTOWN, MD 21742

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Ridenour, CHARLOTTE

NAME: RIDENOUR,CHARLOTTE LOUISE DOS:
03/21/1933 66 / F


H3040990511


H048644

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39735

Physician / Medical Examiner

1. Decedent's Name (First, Middle, Last): RICHARD CHARLES RYAN
2. Date of Death (Month, Day, Year): November 25, 1999
3. Time of Death: 3:00 A.M.
4a. Facility Name (If not institution, give street and number): Franklin Woods Nursing Home & Elder Care
4b. City, Town, or Location of Death: Rossville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 118-03-4739
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 27, 1917
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Abingdon
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 610 Otter Point Road
10f. Zip Code: 21009
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1939-45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): — College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chief Executive Officer
16b. Kind of Business/Industry: Furniture Company

17. Father's Name (First, Middle, Last): Charles A. Ryan
18. Mother's Neme (First, Middle, Melden Sumame): Lucille Bessie Geer

19a. Informant's Neme/Relationship (Type, Print): Lillian M. Ryan - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 610 Otter Point Rd., Abingdon, Maryland 21009

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bel Air Memorial Grdns. — Dele: 11/29/99
20c. Location - City or Town, Stete: Bel Air, Maryland

21. Signature of Funeral Service Licensee: Stanley A. Hughs
22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009

Physician / Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PNEMONIA — 2 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24e. Wes an eutopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was cese referred to medicel examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatienl 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☑ **Certifying Phyalcian:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date and piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: S. Raguseo
29c. License number: D 53720
29d. Date signed (Month, Day, Year): BR 6070508

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): 2112, Belair Road Suite #9, Fallston, MD 21047.

State Registrar

31. Dete filed (Month, Day, Year): NOV 3 0 1999
32. Registrar's Signature: Donna G. Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39736

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Blanche Ruth Reader

2. Date of Death (Month, Day, Year): November 30 1999

3. Time of Death: 8:15am

4a. Facility Name (If not institution, give street and number): Magnolia House Senior Care

4b. City, Town, or Location of Death: Monrovia

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 199-07-9298

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 12, 1919

9. Birthplace (State or Foreign Country): Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Monrovia

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 12526B Fingerboard Road

10f. Zip Code: 21770

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home.

17. Father's Name (First, Middle, Last): Jerry Mairs

18. Mother's Name (First, Middle, Maiden Surname): Ruth Ann Conrad

19a. Informant's Name/Relationship (Type, Print): Kenneth R. Reader - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12729 Fingerboard Road, Monrovia, Maryland 21770

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Providence Methodist Cem. | Date: 12/3/99

20c. Location - City or Town, State: Monrovia, Maryland

21. Signature of Funeral Service Licensee: Robert L. Williams

22. Name and Address of Facility: Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	prob. cerebral vascular accident	hours.
Due to (or as a consequence of): b.	Hypertensive Cardiovascular Disease	years
Due to (or as a consequence of): c.	arteriosclerosis	years.
Due to (or as a consequence of): d.		

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D26499

29d. Date signed (Month, Day, Year): 11-30-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ronald E. Miller, M.D. 4 Culwell Drive, Mt. Airy, Maryland 21771

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999

32. Registrar's Signature: Donna G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39737

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HELEN L. RABB
2. Date of Death (Month, Day, Year): November 25, 1999
3. Time of Death: 12:25 P.M.
4a. Facility Name (If not institution, give street and number): 12005 Scovell Terrace
4b. City, Town, or Location of Death: Germantown
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 227-48-3367
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Dec. 24, 1938
9. Birthplace (State or Foraign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Germantown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 12005 Scovell Terrace
10f. Zip Code: 20874
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 5 Years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Health Planner
16b. Kind of Business/Industry: U. S. Government

17. Father's Name (First, Middle, Last): Emanuel Yavner
18. Mother's Name (First, Middle, Maiden Surname): Celia Wainger

19a. Informant's Name/Relationship (Type, Print): Charles Rabb - Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12005 Scovell Terrace, Germantown, Maryland 20874

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Judean Memorial Gardens | Data: 11/28/99
20c. Location - City or Town, State: Olney, Maryland

21. Signature of Funeral Service Licensee: Donald C. Stottlemyer
22. Name and Address of Facility: Danzansky-Goldberg Memorial Chapel, Inc. 1170 Rockville Pike, Rockville, Maryland 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acute Respiratory Failure — Acute

Due to (or as a consequence of): Probable Pulmonary Embolis — Acute

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

GERD, Bronchitis

Chronic Anxiety - Depression

Chronic Severe Back Pains

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John S. Saia MD
29c. License number: D 10493
29d. Date signed (Month, Day, Year): November 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John S. Saia, M. D. 809 Viers Mill Road, Rockville, Maryland 20851

State Registrar

31. Data filed (Month, Day, Year): NOV 26 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39738

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Glen Paul Raddatz

2. Dete of Deeth: Month November Dey 25, Year 1999

3. Time of Death: 6:10PM

4a Facility Name (If not institution, give street and number): Stella Maris

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 388-05-2884

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 10, 1917

9. Birthplace (State or Foreign Country): Wisconsin

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2300 Dulaney Valley Road

10f. Zip Code: 21204

10g. Citizen of Whet Country?: United States

11. Marital Stetus: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanical Engineer

16b. Kind of Business/Industry: Martin Marietta

17. Father's Neme (First, Middle, Last): Edward Raddatz

18. Mother's Name (First, Middle, Maiden Surname): Marie Arnold

19e. Informent's Neme/Reletionship (Type, Print): Bonnie Kensington/ Daughter

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 18921 Gunpowder Road Manchester, Maryland 21102

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory, Inc.

Date: 11/26/99

20c. Location - City or Town, Stete: Beltsville, Maryland

21. Signeture of Funeral Service Licensee: Laura C. Hardesty

22. Name and Address of Feciility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Drive Baltimore, Maryland 21286

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

b

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert teilure. List only one cause on eech line.

Approximete Interval Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in death): a. Cerebrovascular accident-

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☐ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, etreet, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end pleca, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D43725

29d. Date signed (Month, Dey, Year): 11/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TARIQ MAHMOOD 821 N. Eutaw St #308 Baltimore MD 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Raddatz, Glen P.

3

State Registrar

31. Date filed (Month, Day, Year): NOV 26 1999

32. Registrar's Signature: Jeanne G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39739

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WALTON THOMAS RASIN, JR.
2. Date of Death Month: November Day: 23, Year: 1999
3. Time of Death: 2120
4a. Facility Name (If not institution, give street and number): Deaton Medical and Rehabilitation Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 220 64 1036
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 46 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 4, 1953
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3211 Lake Ave.
10f. Zip Code: 21213
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [XX] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: X
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Walton Thomas Rasin
18. Mother's Name (First, Middle, Maiden Surname): Natalie Atwood

19a. Informant's Name/Relationship (Type, Print): Natalie Atwood / Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 432 Bonsal St., Baltimore, MD 21224

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Chesapeake Crematory Inc. Date: 11/26/99
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Stephen D Lohrmann
22. Name and Address of Facility: Rapp Funeral and Cremation Services, Stephen D. Lohrmann P.A., 933 Gist Ave., Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. DISSEMINATED/CNS MYCOBACTERIUM KANSASII INFECTION — MONTHS

Due to (or as a consequence of):
b. ADVANCED AIDS — YEARS

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

AZOLE-RESISTANT ESOPHAGEAL CANDIDIASIS, WASTING

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to complation of causa of death? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Phyalcian**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D52394
29d. Date signed (Month, Day, Year): 11-24-1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ila Mulasi, 611 S. Charles Street, Baltimore MD 21230

State Registrar

31. Date filed (Month, Day, Year): NOV 26 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

RASIN, Walton Thomas JR.

1+1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39740

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy L. Ricketts

2. Date of Death: Month November Day 28 Year 1999

3. Time of Death: 5:13 AM

4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 219-64-3772

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 12, 1914

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 704 Lake Drive

10f. Zip Code: 21158

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Lester Clark Watkins

18. Mother's Name (First, Middle, Maiden Surname): Bessie Theoria Wallach

19a. Informant's Name/Relationship (Type, Print): William D. Ricketts, Sr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 704 Lake Drive, Westminster, Maryland 21158

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Lakeview Memorial Park

Date: Dec. 1, 1999

20c. Location - City or Town, State: Sykesville, Maryland

21. Signature of Funeral Service Licensee: Ray Funk M00198

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

b. PNEUMONIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. BACTEREMIA

Due to (or as a consequence of):

d. UTI

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ACUTE RENAL FAILURE

CONGESTIVE HEART FAILURE

RESPIRATORY FAILURE.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: H5 12800

29d. Date signed (Month, Day, Year): November 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

13219 EXECUTIVE PARK TERRACE GERMANTOWN MD 20874, AUSH DADGAR, DO

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999

32. Registrar's Signature: [signature] G. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39741

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Albert Ernest Robinson
2. Data of Death — Month: November Day: 26 Year: 1999
3. Time of Death: 8:50 P.M.
4a. Facility Name (If not institution, give street and number): 14600 Perrywood Drive
4b. City, Town, or Location of Death: Burtonsville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-18-0972
6. Sex: ☒ M ☐ F
7. Age (In yrs. last birthday): 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): November 7, 1910
9. Birthplace (State or Foreign Country): South Carolina

Usual Residance of Decedant

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Burtonsville
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 14600 Perrywood Drive
10f. Zip Code: 20866
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Navar Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elemantary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Printer
16b. Kind of Business/Industry: Printing

17. Father's Name (First, Middle, Last): Albert Ernest Robinson Sr.
18. Mother's Name (First, Middle, Maiden Surname): Nellie Spies

19a. Informent's Name/Relationship (Type, Print): Lawrence H. Robinson/ Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14600 Perrywood Drive, Burtonsville, MD 20866

20a. Mathod of Disposition: 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Geo, Wash. University Medical Center
Date: November 26, 1999
20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 20037

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haert tailura. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Causa (Final disaasa or condition resulting in death)	a. Congestive Heart Failure	wks.
Due to (or as a consequence of):	b. ASVD	years
Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Lest	c. Hypertension	year
Due to (or as a consequence of):	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be datarmined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D 11438
29d. Data signed (Month, Day, Year): 11/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marvin Schneider, M.D. 12001 Ferrara Avenue, Wheaton, MD 20906

State Registrar

31. Data filed (Month, Day, Year): NOV 29 1999
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39742

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JANSEN HASBROUCK ROGERS
2. Date of Death: Month November Dey 29 Year 1999
3. Time of Death: 0410
4a. Facility Name (If not institution, give street and number): 1300 Sarah Drive
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 089-03 0631
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): November 9, 1920
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1300 Sarah Drive
10f. Zip Code: 20904
10g. Citizen of What Country?: USA

11. Meritel Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Yeer or Dates: 10/8/40-9/30/66
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Lieutenant Colonel
16b. Kind of Business/Industry: United States Army
17. Fether's Neme (First, Middle, Last): William Butler Fitch Rogers
18. Mother's Name (First, Middle, Maiden Surneme): Helena Jansen Hasbrouck
19a. Informent's Neme/Reletionship (Type, Print): Mary R. Rogers/Wife
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1300 Sarah Drive, Silver Spring, Maryland 20904
20a. Method of Disposition: 1 ☐ Buriet 2 ☒ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Ft. Lincoln Crematory
Dete: 12/1/99
20c. Location - City or Town, Stete: Brentwood, Maryland
21. Signature of Funeral Service Licensee: Charles E. Smith
22. Neme end Address of Facility: Hines-Rinaldi Funeral Home 11800 New Hampshire Ave., Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Deeth
Immediate Cause (Final disease or condition resulting in death)	a. LUNG CANCER, NON-SMALL CELL	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last	b. COPD	
	Due to (or es e consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Pert II. **Other eignificant conditione** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Wes en autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings aveileble prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Deeth (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Menner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year): NOV 29 99
28b. Time of Injury: M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and piece, and due to the ceuse(s) and menner steted.

29b. Signature end title of certifier: Carl L. Hazlett
29c. License number: MD-0584304
29d. Date signed (Month, Day, Year): 11/29/99

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): CARL L. WILLIS 6900 GEORGIA AVE, NW #98, WASHINGTON, DC 20307

State Registrar

31. Dete filed (Month, Day, Year): DEC 03 1999
32. Registrer's Signeture: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39743

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Verna M. Rogers

2. Date of Death (Month, Day, Year): November 29, 1999

3. Time of Death: 8:55 AM

4a. Facility Name (If not institution, give street and number): Rockville Nursing Home

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 154-12-4778

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 98 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 29, 1901

9. Birthplace (State or Foreign Country): New Jersey

Usual Residance of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 303 Adclare Road

10f. Zip Code: 20850

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☒ Yes 2☐ No. If Yas, Giva Yaar or Datas: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12) | College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Musician/Self-Employed

16b. Kind of Business/Industry: Music

17. Father's Name (First, Middle, Last): C. Allen Rogers

18. Mother's Name (First, Middle, Maiden Surname): Clara L. Hendrickson

19a. Informant's Name/Relationship (Type, Print): Virginia R. Christopher/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1006 Azalea Drive, Rockville, Maryland 20850

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donalion 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cemetary, crematory or other place): Greenwood Cemetery

Data: Dec. 3, 1999

20c. Location - City or Town, State: Hamilton Township, NJ

21. Signatura of Funaral Service Licensee: ▶ Will E Bowen Jr M00672

22. Nama and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart feilura. List only ona cause on each line.

Approximate Interval Between Onset and Death

Immediete Ceusa (Final disaase or condition resulting in deeth)

a. Cardiac Arrhythmia — Few Minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immadiata cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cardiac Failure

Due to (or as a consequence of):

c. Old Age

Due to (or as a consequence of):

d.

Part II. Other signiftcant conditiona contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was casa referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Deta of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signatura and title of certifier: ▶ Frauke Westphal

29c. License number: D0019785

29d. Data signed (Month, Day, Year): November 29, 1999

30. Name and address of person who completed causa of daath (Item 23a) (Type, Print): Frauke Westphal, M.D., 809 Veirs Mill Road, #101, Rockville, Maryland 20851-1689

State Registrar

31. Deta filed (Month, Day, Year): DEC 01 1999

32. Registrar's Signature: ▶ Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #18, 19a, 12/6/99,BMW,Montg.Co.

Certificate of Death

Reg. No. 99 39744

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HELMA RAE ROSE

2. Date of Death (Month, Day, Year): 12/01/1999

3. Time of Death: 6:30 PM

4a. Facility Name (If not institution, give street and number): MANOR CARE-POTOMAC

4b. City, Town, or Location of Death: POTOMAC

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 202.12.7453

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 09.23.1923

9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD

10b. County: MONTGOMERY

10c. City, Town or Location: POTOMAC

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 10031 COUNSELMAN ROAD

10f. Zip Code: 20854

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ADMINISTRATIVE ASSSISTANT

16b. Kind of Business/Industry: JEWELRY

17. Father's Name (First, Middle, Last): HARRY BLUM

18. Mother's Name (First, Middle, Maiden Surname): ~~DEAN~~ BERGER Deana

19a. Informant's Name/Relationship (Type, Print): Deana ~~DEAN~~ HALPERIN/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10031 COUNSELMAN ROAD, POTOMAC, MARYLAND 20854

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piece): WASHINGTON HEBREW CON MP

Date: 12.3.99

20c. Location - City or Town, State: WASHINGTON, D.C.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS — DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES

DEMENTIA

DEPRESSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Michael J. Grady

29c. License number: D0038781

29d. Date signed (Month, Day, Year): 12/02/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 4910 MASSACHUSETTS AVE., N.W., SUITE 312, WASHINGTON, DC 20016 DR. MICHAEL GRADY

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39745

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lee Williams Rothman

2. Date of Death (Month, Day, Year): November 25, 1999

3. Time of Death: 12:28 AM

4a. Facility Name (If not institution, give street and number): Casey House

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 302-42-0924

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 52 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 22, 1947

9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10913 Pebble Run Drive

10f. Zip Code: 20902

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Spiritual Advisor

16b. Kind of Business/Industry: Self-Employed

17. Father's Name (First, Middle, Last): Lawrence Michael Williams

18. Mother's Name (First, Middle, Maiden Surname): Mary Jo Lehman

19a. Informant's Name/Relationship (Type, Print): Patricia W. Szmania (sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1414 Roanwood Drive, Houston, Texas 77090

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory | Date: 11-27-99

20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Carol A Dehn

22. Name and Address of Facility: Rapp Funeral & Cremation Services, Stephen D. Lohrmann, PA 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Carcinomia	2 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Lung Cancer	6 months
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: E.P. Libre M.D.

29c. License number: D09470

29d. Date signed (Month, Day, Year): November 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eugene P. Libre, M.D., 10400 Connecticut Avenue, Kensington, MD 20895

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999

32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39746

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rosita Amie Rust
2. Data of Death Month Day Yaar: November 28, 1999
3. Tima of Deeth: 9:20 pm
4a. Facliity Nema (If not institution, give street and number): 11207 Woodson Avenue
4b. City, Town, or Location of Death: Kensington
4c. County of Death: Montgomery

Funeral Director

5. Social Security Numbar: 552-34-1944
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Aug 31, 1907
9. Birthplace (State or Foraign Country): Guatemala

Usual Rasidance of Dacedent

10a. Stata: Maryland
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 11207 Woodson Avenue
10f. Zip Coda: 20895
10g. Citizan of What Country?: USA

11. Maritai Status: 1☐ Nevar Married 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Wes Decedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No — If Yas, Give Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Raca - Amarican Indian, Black, Whita, atc. Specify: White

15. Decedant's Education (Specify only highast grada compiated): Elementary/Secondary (0-12): Coliaga (1-4or 5+): 5+
18a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired): X-ray technologist
16b. Kind of Business/Industry: Health Care

17. Fathar's Name (First, Middle, Last): Jose Jauregui de la Cerda
18. Mothar's Name (First, Middle, Maidan Surneme): Octivie Jauregui de la Cerda

19a. Informant's Neme/Raiationship (Type, Print): Mary Amaryllis McCumber/Daughter
19b. Meiling Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda): 11207 Woodson Ave., Kensington, MD 20895

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramovei from Stata 4☐ Donetion 5☐ Othar (Specify)
20b. Place of Disposition (Nama of cametary, cramatory or othar piece): Metropolitan Crematory
Deta: Dec 1 1999
20c. Location - City or Town, Stata: Alexandria, VA

21. Signature of Funeral Sarvice Licensee: ▶ J. Kein Stiles
22. Nama end Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused tha daath. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, shock, or haart lailure. List only one causa on aach lina. — Approximate Intarval Between Onset end Deeth

Immediata Causa (Finai disaasa or condition rasulting in daeth):
a. Respiratory Arrest
Due to (or as a consequence of):
b. Lung Cancer
Sequantially list conditions, if eny, iaading to immadiate causa. Entar Underlying Cause (Disaase or injury that initiated avants rasulting in death) Last
Due to (or es a consaquance of):
c.
Dua to (or as a consequance of):
d.

Part ii. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part i.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an eutopsy performed? 1☐ Yas 2☒ No
24b. Wara eutopsy findings availabie prior to completion of cause of daath? 1☐ Yas 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was casa relarred to medical examinar? 1☐ Yas 2☒ No
28. Place of Death (Check only ona): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Home 5☒ Rasidanca 8☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding invastigation 8☐ Could not be datarmined
28a. Data of Injury (Month, Day Year)
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifiar (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and piace, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and menner statad.

29b. Signature end titia of certifier: ▶ E. Bodurian
29c. Licansa number: D0028064
29d. Data signed (Month, Day, Year): 11/29/99.

30. Nama and addrass of person who compiated causa of daath (Item 23a) (Type, Print): Edward N. Bodurian, M.D. 5530 Wisconsin Ave., Suite 515, Chevy Chase, MD 20815

State Registrar

31. Data filed (Month, Day, Year): NOV 30 1999
32. Registrar's Signature: Anna G. Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours aftar death with tha Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours aftar death.
To the Funeral Director: Aftar this certificate has been signed by the attanding physician and completely filled in by tha funeral director, page 2 should be detached for usa as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39747

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLARD RYAN
2. Dete of Deeth: Month 11 Dey 27 Yeer 1999
3. Time of Death: 4 P.M.
4e. Feclity Neme (If not institution, give street and number): Mariner Health - Kensington
4b. City, Town, or Locetion of Deeth: Kensington
4c. County of Death: Montgomery

Funeral Director

5. Sociel Security Number: 577-05-1889
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 89 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): Jan 28, 1910
9. Birthplece (Stete or Foreign Country): West Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10e. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street end Number: 10122 Hereford Place
10f. Zip Code: 20901
10g. Citizen of Whet Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Rece - Americen Indien, Bleck, White, etc. Specify: White

15. Decedent's Eduction (Specify only highest grade completed): Elementery/Secondery (0-12); College (1-4or 5+): 2
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Manager
16b. Kind of Business/Industry: Safeway

17. Fether's Neme (First, Middle, Last): Sanfred E. Ryan
18. Mother's Name (First, Middle, Maiden Surname): Ida Maust

19a. Informent's Name/Relationship (Type, Print): Robert L. Ryan / Son
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 911 Kerwin Road, Silver Spring, MD 20901

20e. Method of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, crematory or other place): Parklawn Memorial Park
Dete: Nov 30 1999
20c. Locetion - City or Town, Stete: Rockville, MD

21. Signeture of Funeral Service Licensee: Robert E Ramsey
22. Neme end Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Pert1. Enter the diseese, or complications thet cause the death. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert feilure. List only one ceuse on e ch line.

Approximete Interval Between Onset end Deeth

Immediate Ceuse (Finel diseese or condition resulting in deeth): e. Stroke — Jears

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediete ceuse. Enter Underlying Ceuse (Disease or Injury Ihet initiated events resulting in deeth) Lest:
b. Atherosclerosis — years.
Due to (or es e consequence of):
c.
Due to (or as a consequence of):
d.

Pert II. **Other eignificant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.: Chronic Brain syndrome.

23b. Did tobacco uee contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No

25. Wes cese referred to medicel examiner? 1 ☐ Yes 2 ☒ No

26. Piece of Death (Check only one): Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA; Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Deeth: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Locetion (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es stated. 2 ☐ **Medical Examiner:** On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier: Hugo G Graziani MD
29c. License number: DO 81 88
29d. Date signed (Month, Day, Year): Nov. 28, 1999.

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): HUGO G GRAZIANI MD 717 PERSHING Drive Silver Spring, MD 20910

State Registrar

31. Dete filed (Month, Day, Year): NOV 29 1999
32. Registrer's Signeture: Jeanne G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39748

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Guy Sepielli
2. Date of Death Month Day Year: Nov 30,1999
3. Time of Death: 9:15 A.M.
4e. Facility Name (If not institution, give street and number): Charles County Nursing Center
4b. City, Town, or Location of Death: LaPlata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 163 03 7019
6. Sex: 1☐ M 2☐ F — X
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 1, 1916
9. Birthplace (State or Foreign Country): Crenshaw, PA

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Churchton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1237 Ellicott Ave
10f. Zip Code: 20733
10g. Citizen of Whet Country?: United States

11. Marital Stetus: 1☐ Naver Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Guy Anthony Sepielli
18. Mother's Name (First, Middle, Maiden Surneme): Carmella Sepielli

19e. Informant's Name/Raletionship (Type, Print): Peter Sepielli (SON)
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 1237 Ellicott Ave, Churchton, Maryland 20733

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): St. Dominic's Cemetery — Date: Dec. 5,1999
20c. Location - City or Town, Stete: Philadelphia PA

21. Signature of Funeral Service Licensee ▶
22. Name and Address of Facility: Lee Funeral Home,Inc 6633 Old Alexandria Ferry Road, Clinton,Maryland 20735

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heert feilure. List only one cause on each line.

Approximate Intervel Between Onset and Death

Immediate Ceuse (Final diseese or condition resulting in deeth)
e. HYPOXIA — two HRS

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest
b. RESpiratory Insuffy — few day
Due to (or es a consequence of):
c. CARDIOpulmony disease — YRS
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
ALZEHIMER DISEASE
HYPERTENSION

23b. Did tobecco uae contribute to the ceuse of deeth? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa referred to medical exeminer? 1☐ Yes 2☒ No
26. Piece of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Manner of Death: 1☐ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, dete and placa, end due to the ceuse(s) and menner as stated. 2☐ Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the ceuse(s) and menner stated.

29b. Signature end title of certifier ▶
29c. Licensa number: D-44436
29d. Deta signed (Month, Dey, Year): DEC-1-1999

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): Ashvin Patel, M.D. P.O. Box 1620 , Waldorf, Maryland 20604

State Registrar

31. Data filed (Month, Day, Year): DEC 03 1999
Registrar's Signatura

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39749

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Pauline Stack
2. Date of Death (Month, Day, Year): November 30, 1999
3. Time of Death: 8:15AM
4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 219-42-4643
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 17, 1924
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: District Heights
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2116 Scott Key Drive
10f. Zip Code: 20747
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Food Service
16b. Kind of Business/Industry: Prince George's County Schools

17. Father's Name (First, Middle, Last): Robert Oswald Boteler
18. Mother's Name (First, Middle, Maiden Surname): Isabel Irene Padgett

19a. Informant's Name/Relationship (Type, Print): Judy Stack (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 596 Shadyside Maryland 20764

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland State Veterans Cem. Date: Dec. 7, 1999
20c. Location - City or Town, State: Cheltenham, Maryland

21. Signature of Funeral Service Licensee: ▶ Kelli R. Potter
22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION
Due to (or as a consequence of):
b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or as a consequence of):
c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): N/A
28b. Time of Injury: N/A M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: N/A
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): N/A
28f. Location (Street and Number or Rural Route Number, City or Town, State): N/A

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Victor E. Henry MD
29c. License number: D20986
29d. Date signed (Month, Day, Year): DEC 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Victor E. Herry, M.D. 11701 Livingston Road #309, Fort Washington, MD 20774

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999
32. Registrar's Signature:

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DEC 0 3 1982

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39750

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Phyllis Madeline Sawyer
2. Date of Death (Month, Day, Year): November 30, 1999
3. Time of Death: 8:10 p.m.

4a. Facility Name (If not institution, give street and number): Larkin Chase Nursing and Restorative Center
4b. City, Town, or Location of Death: Bowie
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-42-6147
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 4, 1910
9. Birthplace (State or Foreign Country): Maine

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Berwyn Heights
10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5811 Goucher Drive
10f. Zip Code: 20740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales Clerk
16b. Kind of Business/Industry: Retail Sales

17. Father's Name (First, Middle, Last): Dayton Michael Hannaford
18. Mother's Name (First, Middle, Maiden Surname): Carrie Scanlon

19a. Informant's Name/Relationship (Type, Print): Rena J. Brewrink - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5811 Goucher Drive, Berwyn Heights, MD 20740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Riverside Cemetery
Date: 05/2000
20c. Location - City or Town, State: Orono, Maine

21. Signature of Funeral Service Licensee: Claudette L. Gasch
22. Name and Address of Facility: Gasch's Funeral Home 4739 Baltimore Ave., Hyattsville, MD 20781

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. RESPIRATORY FAILURE. — < one-week.

Due to (or as a consequence of):
b. MAL NUTRITION.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

Due to (or as a consequence of):
c. DEMENTIA - ADVANCED.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypothyroidism.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D-34525
29d. Date signed (Month, Day, Year): December 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sankineni J. Rao, M.D. 4000 Mitchellville Road, #220, Bowie, MD 20716

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

DEC 0 3 1938

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39751

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary M. Shaughnessy
2. Data of Daath: Month 11 Day 24 Year 1999
3. Tima of Daath: 6 30 AM
4a. Facility Neme (If hot institution, giva street end number): Holly Hill Manor
4b. City, Town, or Location of Daath: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Sociel Security Number: 217-16-0447
6. Sax: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): May 13, 1906
9. Birthplaca (Stata or Foraign Country): Washington DC.

Usual Rasidance of Decedant

10a. Stete: Maryland
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Insida City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5610 York Rd. #302
10f. Zip Coda: 21212
10g. Citizan of Whet Country?: United States

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Dacedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No — If Yas, Giva Yeer or Datas:
13. Wes Decedant of Hispanic Origin? (Spacify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Raca - American Indian, Black, White, atc. Specify: White

15. Decedant's Education (Specify only highast grade complated): Elamantary/Secondary (0-12): 4 — Collaga (1-4or 5+):
16a. Decedant's Usual Occupetion (Giva kind of work done during most of working life. DO NOT usa retired): Homemaker
16b. Kind of Businass/Industry: Domestic

17. Fathar's Name (First, Middla, Last): William Carrico
18. Mothar's Nama (First, Middle, Meidan Sumama): Emma Kile

19a. Informant's Name/Relationship (Type, Print): John Shaughnessy / Son
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Coda): 1660 Georgetowne Blvd, Sarasota, FL 34232

20a. Method of Disposition: 1☒ Burial 2☐ Crametion 3☐ Ramoval from State 4☐ Donation 5☐ Othar (Specify)
20b. Placa of Disposition (Name of cematary, cramatory or other piece): New Cathedral Cemetery — Data: 11/29/99
20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funeral Service Licensee: Stephen D. Lohrmann
22. Nama and Addrass of Facility: CAFAStephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complications that caused the deeth. Do not antar the moda of dying, such as cardiec or respiratory arrast, shock, or haart failura. List only ona causa on aach lina.

		Approximata Intarval Between Onset and Death
Immediata Ceuse (Finel disease or condition rasulting in death) a.	coronary artery disease	20 years
Dua to (or as a consequance of):		
Sequantially list conditions, if any, leading to immadiata causa. Enter Underlying Ceuse (Disease or Injury thet initiated events rasulting in death) Last b.		
Dua to (or as a consequance of):		
c.		
Dua to (or as a consequance of):		
d.		

Part II. **Other significent conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.: COPD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to compiation of cause of death? 1☐ Yes 2☑ No

25. Was casa rafarred to medical examiner? 1☐ Yes 2☑ No

26. Placa of Deeth (Check only ona): Hospital: 1☐ Inpatiant 2☐ ER/Outpetient 3☐ DOA — Othar: 4☑ Nursing Home 5☐ Residance 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be datarmined

28a. Deta of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Steta)

29a. Cartifier (Check only one): 1☑ **Certifying Physician:** To tha best of my knowledga, daath occurred at the time, date and place, end due to the ceuse(s) end manner es stated. 2☐ **Medical Examinar:** On the basis of examination and/or invastigation, in my opinion, daath occurred et the time, data and place, and dua to tha cause(s) and mennar stated.

29b. Signature and title of certifier
29c. License number: D41104
29d. Dete signed (Month, Dey, Year): 11 24 99

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print): Ted Houk MD 7825 York Rd Towson MD 21204.

State Registrar

31. Data filed (Month, Day, Year): NOV 30 1999
32. Registrar's Signatura

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after daath with tha Maryland Department of Haalth and Mental Hygiena. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requires that the death certificata be executed within 24 hours after death.
To the Funeral Director: Aftar this certificata has been signed by the attanding physician and completaly filled in by tha funeral director, page 2 should be detached for usa as the burial-transit

(3)

DHMH 16 Rav 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39752

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Earselean Sullivan
2. Date of Death Month Day Year: November 20, 1999
3. Time of Deeth: 8:00 p.m.
4e. Feclity Name (If not institution, give street and number): Golden Oaks Nursing & Rehabilitation Center
4b. City, Town, or Location of Deeth: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579 26 5811
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): Sept. 1,1906
9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Laurel
10d. Inside Clty Limits: 1☒Yes 2☐No
10e. Street and Number: 9001 Cherry Lane
10f. Zip Code: 20708
10g. Citizen of What Country?: USA
11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic
16b. Kind of Business/Industry: Private
17. Fether's Neme (First, Middle, Last): George Rowland
18. Mother's Name (First, Middle, Maiden Surname): Missouri Rhodes
19a. Informant's Name/Relationship (Type, Print): John Rowland/ grandson
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 505 Jones Falls Court Bowie, MD 20721
20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)
20b. Placa of Disposition (Neme of cemetery, crematory or other placa): Fort Lincoln Cemetery
Date: 11-27
20c. Location - Clty or Town, State: Brentwood, MD
21. Signature of Funeral Service Licensee: ▶ Suawara L. Braxton
22. Name and Address of Facility: MARSHALL'S FUNERAL HOME OF MD 4308 Suitland Road Suitland, MD 20746

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. DEHYDRATION — WEEKS

Due to (or as a consequenca of):
b. ORGANIC BRAIN SYNDROME — YEARS

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or es a consequence of):
d.

Part II. **Other signiticant conditiona** contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION
SEIZURE DISORDER

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings availeble prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Piece of Death (Check only one): Hospitel: 1☐inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28e. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: ▶ MD
29c. License number: D25422
29d. Date signed (Month, Day, Year): NOVEMBER 23, 1999

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): ROBERT Y. MAGGIN, MD — 13952 BALTIMORE AVE, LAUREL, MARYLAND 20707

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999
32. Registrer's Signature: Barbara A. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

NOV 3 0 1988

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39753

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CARL R. SCHLEICHER
2. Date of Death — Month / Day / Year: NOV. 25, 1999
3. Time of Death: 11:48 AM
4a. Facility Name *(If not institution, give street and number)*: HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 147-26-4249
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 66 Yrs.
If Under 1 Year — Months / Days
If Under 24 Hrs. — Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 5, 1933
9. Birthplace *(State or Foreign Country)*: Reading, Pa.

Usual Residence of Decedent

10a. State: N.J.
10b. County: Morris
10c. City, Town or Location: Boonton
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 324 Church Street
10f. Zip Code: 07005
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: 1956-1966
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4 or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: President, Mankind Research
16b. Kind of Business/Industry: Medical Research

17. Father's Name *(First, Middle, Last)*: Earl J. Schleicher
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary E. Reynolds

19a. Informant's Name/Relationship *(Type, Print)*: Cheryl Schleicher/Sister
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 324 Church Street, Boonton, N.J. 07005

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Mary's Cemetery — Date: 11/29/99
20c. Location - City or Town, State: Boonton, N.J.

21. Signature of Funeral Service Licensee: Philip D. Knuth
22. Name and Address of Facility: Lewis & Carey, Directors of Funerals, 312 West Main Street, Boonton, N.J. 07005

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Ischemic Heart Disease — 1 yr
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Renal Failure

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D 20674
29d. Date signed *(Month, Day, Year)*: November 26, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen Hellman MD 6240 Montrose Rd, Rockville MD 20852

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 29 1999
32. Registrar's Signature:

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

9-24-01 JAB
AMND ITM#10a-c & 10f&e PR. F.H. G799

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 99 39754

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Robert Stoner
2. Date of Death (Month, Day, Year): November 23, 1999
3. Time of Death: 5:30 AM
4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 234-42-4298
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 3, 1929
9. Birthplace (State or Foreign Country): Huntington, WV

Usual Residence of Decedent

10a. State: W.V. ~~MD~~
10b. County: CABELL ~~Montomgery~~
10c. City, Town or Location: HUNTINGTON ~~Barnesville~~
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 416 FERGUSON ROAD ~~17201 Old Baltimore Road~~
10f. Zip Code: 25705-1609 ~~20838~~
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Building Contractor
16b. Kind of Business/Industry: Building

17. Father's Name (First, Middle, Last): Ray M. Stoner
18. Mother's Neme (First, Middle, Malden Surname): Mary Lee Farley

19a. Informant's Name/Reietionship (Type, Print): Betty Porter Stoner - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17201 Old Baltimore Road Barnesville, MD 20838

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cametery, crematory or other placa): Woodmere Memorial Park
Date: 11/27/99
20c. Location - City or Town, State: Huntington, WV

21. Signature of Funeral Service Licansee: Allen L. Woodall
22. Name and Address of Facility: Capitol Funeral Service, Inc. 7211 Lee Hwy Falls Church, VA 22046

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death)	a. ADULT RESPIRATORY DISTRESS SYNOROME	10 DAYS
	Due to (or as a consequence of):	
Sequentially iist conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last	b.	
	Due to (or es e consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.

LUNG CANCER

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cauee of death? 1 [ ] Yee 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Piece of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 [X] **Certifying Phyeician:** To the best of my knowledge, death occurred et the time, date and pleca, and due to the ceuse(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Carl J. Schoenberger MD
29c. License number: D 26540
29d. Date signed (Month, Dey, Year): NOV 23 1999

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): Carl J. Schoenberger 16220 Frederick Rd Gaithersburg MD.

State Registrar

31. Date filed (Month, Day, Year): DEC 17 1999
32. Registrar's Signature: [illegible] Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39755

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Emory Sturgill
2. Date of Death Month Day Year: Dec. 5, 1999
3. Time of Death: 1:52 PM

4a Facility Name *(If not institution, give street and number)*: 18329 Peters Avenue
4b. City, Town, or Location of Death: White Hall
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 226-16-1834
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Aug. 28, 1918
9. Birthpleca *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. Stata: MD
10b. County: Baltimore
10c. City, Town or Location: White Hall
10d. Insida City Limits: 1 [ ] Yas 2 [X] No
10e. Street and Number: 18329 Peters Avenue
10f. Zip Code: 21161
10g. Citizan of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yas 2 [ ] No If Yas, Giva Year or Datas: WW II
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No *Specify:*
14. Race - Amaricen Indian, Black, Whita, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Construction Worker
16b. Kind of Business/Industry: Construction

17. Father's Nema *(First, Middle, Last)*: Henry Sturgill
18. Mother's Nama *(First, Middle, Maiden Surname)*: Mattie Church

19a. Intormant's Neme/Relationship *(Type, Print)*: Mildred Sturgill/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 18329 Peters Ave., White Hall, MD 21161

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Wiseburg Cemetery — Data: Dec. 9, 1999
20c. Location - City or Town, Stete: White Hall, MD

21. Signature of Funeral Service Licensee: [signature]
22. Nama and Address of Facility: J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha death. Do not entar tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart tailure. List *only* one cause on each line. — Approximete Interval Betwean Onset and Death

Immediete Cause (Final disease or condition rasulting in death): a. Lung Cancer
Due to (or as a consequence of):
Sequentially list conditions, if any, laading to immediata ceuse. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last
b.
Due to (or as a consequence of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy partormed? 1 [ ] Yes 2 [X] No
24b. Ware autopsy findings available prior to completion of cause of deeth? 1 [ ] Yas 2 [ ] No

25. Was cese refarred to medical examiner? 1 [ ] Yas 2 [X] No

28. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Mennar of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending invastigation 6 [ ] Could not be datarmined
28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury M
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best ot my knowledge, death occurred at tha tima, data and plece, end due to the causa(s) and menner as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, deeth occurred at tha time, data and place, and dua to the cause(s) and mannar stated.

29b. Signature and title of certifier: [signature]
29c. License number: D26002
29d. Data signad *(Month, Day, Year)*: 12/7/99

30. Neme and address of person who completed ceusa of death (Item 23a) (Type, Print): Dr. John Eppler, 120 Sister Pierre Dr., Towson, MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 17 1999
32. Registrar's Signature: [signature]

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ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39756

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Francis George Smith
2. Date of Death Month / Dey / Yeer: December 6, 1999
3. Time of Death: 5:50 AM
4e. Facility Name *(If not institution, give street end number)*: 864 Smith Lane
4b. City, Town, or Location of Death: Benson
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 219-07-8000
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 88 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 29, 1911
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10e. Stete: Maryland
10b. County: Harford
10c. City, Town or Location: Benson
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 864 Smith Lane
10f. Zip Code: 21018
10g. Citizen of Whet Country?: USA

11. Maritel Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - Americen Indien, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Farmer
16b. Kind of Business/Industry: Dairy Farming
17. Fether's Neme *(First, Middle, Last)*: William John Smith
18. Mother's Name *(First, Middle, Maiden Surneme)*: Mary Ellen Hayes
19e. Informent's Name/Reletionship *(Type, Print)*: E. Virginia Smith / Wife
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 864 Smith Lane, Benson, Maryland 21018
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, crematory or other place)*: St. John's Catholic Cem.
Dete: 12-8-99
20c. Location - City or Town, Stete: Hydes, Maryland
21. Signature of Funeral Service Licensee: Stephen A Meagle
22. Name end Address of Facility: McComas Funeral Home, P.A. 50 W. Broadway St., Bel Air, Maryland 21014

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complicetions that ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximate Intervel Between Onset and Deeth

Immediate Cause (Finel disease or condition resulting in death) e. coronary artery disease — < 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest

b. Due to (or as a consequence of):

c. Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were eutopsy findings evellable prior to completion of ceuse of deeth? 1 ☐ Yes 2 ☒ No

25. Wes cese referred to medicel exeminer? 1 ☐ Yes 2 ☒ No

28. Piece of Death *(Check only one)*: Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner as steted. 2 ☐ **Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: David S Dunn
29c. License number: D32299
29d. Dete signed *(Month, Day, Year)*: December 6, 1999

30. Neme end address of person who completed ceuse of deeth (Item 23a) (Type, Print): DAVID S. DUNN 615 W. MacPHA.

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 07 1999
32. Registrar's Signeture: D. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Smith

Francis

15

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39757

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Johnston SAUM
2. Date of Death (Month, Day, Year): December 5, 1999
3. Time of Death: 4:30 Am
4a. Facility Name (If not institution, give street and number): 1309 Marshall Street
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-09-8950
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 30, 1915
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1309 Marshall Street
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: W.W. II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0-12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): rural mail carrier
16b. Kind of Business/Industry: U.S. Postal Service

17. Father's Name (First, Middle, Last): Charles Haller Saum
18. Mother's Name (First, Middle, Maiden Surname): Mary Susan Johnston

19a. Informant's Name/Relationship (Type, Print): Mrs. Catherine A. Saum / wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1309 Marshall Street, Hagerstown, Maryland 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Othar (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Harbaugh's Cemetery
Date: Dec. 8, 1999
20c. Location - City or Town, State: Rouzerville, Pennsylvania

21. Signature of Funeral Service Licensee: Scott M Minnich
22. Name and Address of Facility: Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland

Physician /Medical Examiner

23a. Part1. Enter the disaase, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on each lina. — Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death)
a. Acute Renal Failure
Dua to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Last
b. severe Hydronephrosis
Due to (or as a consequence of):
c. urinary bladder cancer
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)
28f. Locatlon (Street and Number or Rural Routa Number, City or Town, State)

29a. Cartifier (Check only one): 1☑ **Certifying Physician:** To tha best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at tha tima, data and place, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D50822
29d. Date signed (Month, Day, Year): 12/6/99

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): NEAL PAULINGHAM, M.D SUITE 107 11110 medical campus Rd Hagerstown MD 21742

State Registrar

31. Date filed (Month, Day, Year): DEC 08 1999
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39758

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ANNIE MARIE SMITH
2. Date of Death Month / Day / Year: DECEMBER 4 1999
3. Time of Death: 4:44 P.M.
4a. Facility Name *(If not institution, give street and number)*: FREDERICK MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: FREDERICK
4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 217-56-2169
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Yeer)*: DEC. 14, 1935
9. Birthplace *(Stete or Foraign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: FREDERICK
10c. City, Town or Location: FREDERICK
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 400 TANEY AVENUE
10f. Zip Code: 21702
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ASSEMBLER
16b. Kind of Business/Industry: HANDICAPPED CENTER

17. Father's Name *(First, Middle, Last)*: ROY (NMN) SMITH
18. Mother's Name *(First, Middle, Meidan Surneme)*: ANNIE (UMN) HAUPT

19a. Informant's Name/Relationship *(Type, Print)*: GERALD C. SMITH/BROTHER
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 11 W. BALTIMORE ST., APT. 521, HAGERSTOWN, MD 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other place)*: BOONSBORO CEMETERY
Date: 12/9/99
20c. Location - City or Town, State: BOONSBORO, MARYLAND

21. Signature of Funeral Service Licensee: Paul M Dean
Paul M. Dean
22. Name and Address of Facility: BAST FUNERALHOME 7606 Old National Pike Boonsboro, Maryland 21713

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line.

Approximete Intervel Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
e. sep sis, Rupture Gangrenous Bowel — 12/3/99 1920
Due to (or as a consequence of):
b. incarcerated-strangulated incisional — to 12/4/99 1645
Due to (or as a consequence of):
c. Ventral hernia
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in death) Last

Part II. **Other aignificent conditions** contributing to death but not resulting in the underlying cause givan in Part I.

23b. Did tobacco use contribute to the ceuse of deeth? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were eutopsy findings available prior to completion of causa of deeth? 1☑ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Piece of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of exemination and/or investigetion, in my opinion, death occurred at the time, date end placa, and due to the ceuse(s) end manner stated.

29b. Signature and title of certifier: Nicholas P Foris M.D.
29c. License number: MD D003666
29d. Date signad *(Month, Day, Year)*: 12/6/99

30. Name end addrass of person who completed cause of death (Item 23a) (Type, Print): Nicholas P. Foris, M.D. 74 Thomas Johnson Drive, Frederick, MD 21702

State Registrar

31. Date filed *(Month, Day, Yeer)*: DEC 08 1999
32. Registrar's Signature: Jenna G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39759

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Wilma June Smith
2. Date of Death Month Day Year: Dec. 2 1999
3. Time of Death: 5:50 AM
4a. Facility Name (If not institution, give street and number): Western Maryland Hospital Center
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 579-24-5236
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 8, 1921
9. Birthplace (State or Foreign Country): Kansas

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 16309 McGregor Dr.
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Earl J. Dymond
18. Mother's Name (First, Middle, Maiden Surname): Lucetta G. Heter

19a. Informant's Name/Relationship (Type, Print): Myra K. Smith (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16309 McGregor Dr. Hagerstown, Md. 21740

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory | Date: Dec. 3, 1999
20c. Location - City or Town, State: Smithsburg, Md.

21. Signature of Funeral Service Licensee: Dennis R. Davis
22. Name and Address of Facility: Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Pneumonia — Due to (or as a consequance of): — days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
End Stage Renal Disease on Hemodialysis
Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rose Marie Chan, M.D.
29c. License number: D 76416
29d. Date signed (Month, Day, Year): Dec. 2, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ROSE MARIE CHAN, M.D. 1500 Pennsylvania Ave., Hagerstown, MD 21742

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999
32. Registrar's Signature: G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39760

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mae Catherine Stonesifer

2. Date of Death Month / Day / Year: November 25 1999

3. Time of Death: 0435

4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 215-36-5946

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 9 1913

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Funkstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 20 W. Baltimore Street

10f. Zip Code: 21734

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 8 — College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Packer

16b. Kind of Business/Industry: Ribbon Manufacturer

17. Father's Neme *(First, Middle, Last)*: John Stanley Jones

18. Mother's Name *(First, Middle, Maiden Surname)*: Ella May Bowlus

19a. Informent's Neme/Reletionship *(Type, Print)*: Shirley E. Hays - Daughter

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 22301 Cave Hill Road Smithsburg, Md. 21783

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, crematory or other place)*: Hagerstown Crematory

Dete: 11/29/99

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott M Minnich

22. Name end Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicetions thet caused tha daeth. Do not enter the moda of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

		Approximete Intervel Between Onset and Death
Immediete Cause (Finel diseese or condition resulting in deeth) a.	STROKE	4 DAYS
Due to (or as e consequence of): b.	ATRIAL FIBRILLATION	YEARS
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in deeth) Lest — Due to (or es e consequence of): c.	ATHROSCLEROSIS	YEARS
Due to (or es e consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28b. Time of Injury

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Dete of Injury *(Month, Dey Year)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end piece, and due to the cause(s) and menner steted.

29b. Signature end title of certifier: MD

29c. License number: D44996

29d. Date signed *(Month, Day, Year)*: NOV 25, 1999

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): Zafar Malik 20311 Lappans Rd Boonsboro, MD 21713

State Registrar

31. Dete filed *(Month, Day, Year)*: NOV 29 1999

32. Registrer's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Stonesifer, Mae Catherine

Medical Certification:

99-7195-017
DDG
RETHA K. SMITH

Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

12-20-99AMEND23a PRT. II &27 PER M.E.O. G778 J.A. **Certificate of Death**

Reg. No. 99 39761

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RETHA KAY SMITH
2. Date of Death Month / Day / Year: DECEMBER 1, 1999
3. Time of Death: 1006 AM
4a. Facility Name *(If not institution, give street and number)*: 11842 OAK MANOR DRIVE
4b. City, Town, or Location of Death: WALDORF
4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 220-50-9824
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 52 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: December21,1946
9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Charles
10c. City, Town or Location: Waldorf
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11842 Oak Manor Drive
10f. Zip Code: 20601
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☐ No If Yes, Giva Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 11 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT use ratired)*: Homemaker
16b. Kind of Business/Industry: Home

17. Father's Nama *(First, Middla, Last)*: James William Duckworth
18. Mothar's Nama *(First, Middla, Maiden Sumama)*: Hester Kidd

19a. Informant's Neme/Ralationship *(Type, Print)*: Everett Smith/Husband
19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 11842 Oak Manor Drive Waldorf,MD 20601

20a. Mathod of Disposition: ☒1 Buriel 2☐ Cramation 3☐ Ramovel from Stete 4☐ Donetion 5☐ Othar *(Specify)*
20b. Place of Disposition *(Name of cematary, crematory or other place)*: St. Peters Cemetery — Data: 12/6/99
20c. Location - City or Town, State: Waldorf,Maryland

21. Signeture of Funaral Service Licensee: A C Echols — M00174
22. Nama and Address of Facility: AREHART-ECHOLS FUNERAL HOME,P.A. P.O. BOX 567 LA PLATA,MD 20646

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart feilure. List only one cause on eech line.

Approximata Interval Between Onset and Death

Immediata Causa (Final diseasa or condition resulting in death): a. ACUTE PNEUMONIA

Dua to (or as a consequence of):

Sequentially list conditions, if any, leeding to immadiata cause. Entar Underlying Cause (Diseasa or injury that initiated events resulting in death) Last:
b.
Dua to (or as a consequence of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.: CHRONIC NARCOTISM

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy parformed? 1☒ Yas 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was casa rafarred to medical examinar? 1☒ Yas 2☐ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☒ Residence 6☐ Other *(Specify)*

27. Mannar of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding invastigetion 6☐ Could not be datarmined

28a. Date of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Placa of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Certifiar *(Check only one)*: 1☐ **Certifying Physician:** To tha best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and menner as stated. 2☒ **Medical Examiner:** On tha basis of axamination and/or investigetion, in my opinion, daath occurred at the tima, data and place, end due to the cause(s) and menner steted.

29b. Signature and title of certifiar: Dennis J. Chutkow
29c. Licensa number: O.C.M.E.
29d. Data signed *(Month, Day, Year)*: DECEMBER 2, 1999

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): Dennis J. Chutkow 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 06 1999
32. Registrar's Signatura: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39762

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: EDWARD A. STEWART

2. Dete of Deeth — Month: Nov. Day: 30, Yaar: 1999

3. Time of Death: 5:45 PM

4a Facility Name *(If not institution, give street end number)*: 4810 Archer Road

4b. City, Town, or Location of Death: Whiteford

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 217-36-3785

6. Sex: 1 ☒ M 2 ☐ F

7. Aga *(In yrs. lest birthday)*: 79 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Dey, Year)*: 9/11/1920

9. Birthplaca *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: MD

10b. County: Harford

10c. City, Town or Location: Whiteford

10d. Insida City Limits: 1 ☐ Yes ☒ No

10e. Street and Number: 4810 Archer Road

10f. Zip Code: 21160

10g. Citizen of Whet Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuben, Mexicen, Puerto Rican, atc.) 1 ☐ Yes ☒ No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify*: White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 11

College (1-4or 5+):

16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Dairy Farmer

16b. Kind of Business/Industry: Agriculture

17. Fether's Name *(First, Middle, Last)*: J. Walter Stewart

18. Mother's Name *(First, Middle, Meiden Surneme)*: Edna Wilson

19a. Informent's Name/Relationship *(Type, Print)*: Mildred A. Stewart- wife

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 4810 Archer Rd., Whiteford, MD 21160

20a. Method of Disposition: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Slate Ridge Cemetery

Dete: 12/03/99

20c. Locetion - City or Town, Stata: Delta, PA

21. Signature of Funerel Service Licensea: Jeffrey P. Hovelidge

22. Neme end Address of Facility: Harkins Funeral Home, 600 Main St., Delta, PA 17314

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heert failure. List only one ceuse on each line.

Approximate Interval Between Onset and Deth

Immediate Cause (Final disease or condition resulting in deeth)

a. Respiratory failure see To ALS — 2 mth

Due to (or as a consequence of):

b. Amyotrophic Lateral Sclerosis — 1 yr.

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury thet Initiated events resulting in death) Lest

Due to (or as e consequence of):

c.

Dua to (or as e consequence of):

d. * Supraventricular Tachycardia

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying ceuse given in Part I.

*

23b. Did tobacco uee contributa to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 ☐ Yes 2 ☐ No

25. Was cese referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Tima of injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, streat, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*

1 ☑ **Certifying Phyeician**: To the best of my knowledge, death occurred et the time, date and place, and dua to the ceuse(s) and menner es stated.

2 ☐ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete and place, end due to the ceuse(s) end manner steted.

29b. Signature and title of certifier: Janne Olson MD.

29c. Licansa number: D15044

29d. Date signed *(Month, Dey, Year)*: 12/1/99

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): Janne Olson, MD Webb Lane, Fawn Grove Pa 17321

State Registrar

31. Date filed *(Month, Dey, Year)*: DEC 02 1999

32. Registrar's Signature: Jeanne B. Spratt

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mantal Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours afar death.
To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the funeral director, paga 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39763

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward Joseph Slawski, Sr.

2. Date of Death: Month NOVEMBER Day 28 Year 1999

3. Time of Death: 0424

4a. Facility Name (If not institution, give street and number): Fallston General Hospital

4b. City, Town, or Location of Death: Fallston

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 217-01-4174

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 18, 1916

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1713 Ruger Drive

10f. Zip Code: 21015

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Roller-Steel Mill

16b. Kind of Business/Industry: Cans & Bottle Cap Manufacturing

17. Father's Name (First, Middle, Last): Adam (nmn) Slawski

18. Mother's Name (First, Middle, Maiden Surname): Agnes (nmn) Lukowski

19a. Informant's Name/Relationship (Type, Print): Dorthea A. Slawski/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1713 Ruger Dr., Bel Air, MD 21015

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Bel Air Memorial Gardens | Date: 12-1-99

20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Acute Myocardial Infarction	10 min
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Coronary Artery Disease	20 years
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Gastrointestinal Bleeding

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: 037517

29d. Date signed (Month, Day, Year): November 30 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David C. Rubin 104 Plumtree Rd. Bel Air MD 21015

State Registrar

31. Date filed (Month, Day, Year): DEC 02 1999

32. Registrar's Signature: [signature] G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

SLAWSKI, EDWARD J. SR

127-1

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39764

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HAROLD E. STEWART
2. Date of Death: Month NOVEMBER Day 28 Year 1999
3. Time of Death: 15:23
4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death:

Funeral Director

5. Social Security Number: 162-22-8430
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Sept. 7, 1926
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: PA
10b. County: Dauphin
10c. City, Town or Location: Harrisburg
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3527 Ridgeway Road
10f. Zip Code: 17109
10g. Citizen of What Country?: United States
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Director
16b. Kind of Business/Industry: Cooperative Extension Service
17. Father's Name (First, Middle, Last): John C. Stewart
18. Mother's Name (First, Middle, Maiden Surname): Alice Ruff
19a. Informant's Name/Raletionship (Type, Print): Delores M. Stewart - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3527 Ridgeway Road, Harrisburg, PA 17109
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chanceford Cemetery
Date: 12/2
20c. Location - City or Town, State: Airville, PA
21. Signature of Funeral Service Licensee: Jeffrey P. Lovelidge
22. Name and Address of Facility: Harkins Funeral Home, Inc., Delta, PA

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS; INTRAABDOMENAL — 10 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): NOVEMBER 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter Walinsky, MD Johns Hopkins Hospital 600 N Wolfe St. Baltimore, Md

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999
32. Registrar's Signature: Geneva G. Parks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

99-7234-02
B.K.S
ROBERT ALLEN SAVAGE

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39765

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT A. SAVAGE, SR.
2. Date of Death (Month, Day, Year): DEC. 2, 1999
3. Time of Death: 9: 10 AM
4a. Facility Name (If not institution, give street and number): 9520 MELLOW COURT
4b. City, Town, or Location of Death: LAUREL
4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 220-34-8448
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 23, 1937
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 9520 Mellow Court
10f. Zip Code: 20723
10g. Citizen of What Country?: United States
11. Marital Stetus: 1☐Never Married 2☐Merried 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Heavy Equipment Operator
16b. Kind of Business/Industry: Construction
17. Father's Name (First, Middle, Last): George F. Savage
18. Mother's Name (First, Middle, Maiden Sumeme): Mabel V. Maness
19a. Informent's Name/Reletionship (Type, Print): Thomas M. Savage / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 812-A E. South Street, Frederick, Maryland 21701
20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hagerstown Cermatory
Date: Dec. 5, 1999
20c. Location - City or Town, State: Hagerstown, Maryland
21. Signature of Funeral Service Licensee: D. L. Stauffer
22. Name and Address of Facility: Stauffer Funeral Home, P.A. 1621 Opossumtown Pike, Frederick, Maryland 21702

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. (Approximete Interval Between Onset end Deeth)

Immediate Cause (Final disease or condition resulting in death): a. Contact Gunshot Wound of Chest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other signiticant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uee contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical exeminer? ☒Yes 2☐No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☐Netural 2☐Accident 3☒Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year): Found 12/2/199
28b. Time of Injury: 8 5 1 4 M
28c. Injury at Work? 1☐Yes 2☒No
28d. Describe how injury occurred: Subject shot self
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): residence yard
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete): 9520 Mellow Court Laurel Maryland

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as steted.
☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier: Theodore McKay MD
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): DEC. 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE MCKAY 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year): DEC 06 1999
32. Registrar's Signature: B. Smith

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #7, 11/29/99, BMW, Montg.Co.

Certificate of Death

Reg. No. 99 39766

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
MINNIE	MADEOY	SAMLER	11	27	99	8:05 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HEBREW HOME OF GREATER WASHINGTON	ROCKVILLE	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-05-1358	1☐ M 2☒ F XX	88 ~~87~~ Yrs.					1/5/1911	WASHINGTON, D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	MONTGOMERY	ROCKVILLE	1☒ Yes 2☐ No

10a. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6121 MONTROSE ROAD	20852	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed X 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No X Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		SALESPERSON	RETAIL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
FISHEL MADEOY	DORA FOX

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MORTON SAMLER/SON	10705 GLOXIANIA DRIVE ROCKVILLE, MARYLAND 20852

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial XX 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	MIKRO KODESH CEMETERY	11/29/99	BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC.
1091 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Cerebral vascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☑ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Gary B. Wilks MD	D0055258	November 28, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Gary Wilks, MD Hebrew Home 6121 Montrose Road Rockville, Maryland 20852

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
NOV 29 1999	Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

11/29/99 (Due #31)

Incorrect date 11/26/99 Entered. White out used
+ 11/29/99 Entered. B. McWilliams

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39767

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Dey Yeer	3. Time of Death
VIOLA REBECCA SANTINI	NOVEMBER 26, 1999	8:47 A.M.

4e. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
BROOKE GROVE NURSING HOME	OLNEY	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Yeer)	9. Birthplace (State or Foraign Country)
215-52-5395	1☐ M 2☒ F	92 Yrs.			JULY 27, 1907	MARYLAND

Usuel Residence of Decedent

10e. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	HOWARD	CLARKSVILLE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
12937 KENTBURY DRIVE	21209	UNITED STATES

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.)	14. Race - Americen Indien, Bleck, White, etc.
1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Detes:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grede completed)		16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	Collega (1-4or 5+)		
12	2	HOUSEWIFE	HOME

17. Fether's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
CHARLES EDWARD RICH	RUBY ETTA PARSLEY

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
DOROTHY RENNER - DAUGHTER	15520 SANTINI ROAD, BURTONSVILLE, MARYLAND 20866

20e. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)	UNION CEMETERY	11-29-99	BURTONSVILLE, MD

21. Signature of Funeral Servica Licansee: ▶ Jeffrey Samuel Nigro

22. Name end Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE., SILVER SPRING, MD 20904

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line.

		Approximete Interval Between Onset end Deeth
Immediate Cause (Finel diseese or condition resulting in death)	e. CONGESTIVE HEART FAILURE	Yeers
	Due to (or es e consequence of):	
Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest	b. Due to (or as a consequence of):	
	c. Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24e. Wes an eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☑ No

25. Wes cese referred to medicel exeminer? 1☐ Yes 2☑ No

28. Piece of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death	28a. Date of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Numbar or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☑ **Certifying Physicien**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner stated.

29b. Signeture end title of certifier: ▶ [signature] MD

29c. License number	29d. Date signed (Month, Dey, Yeer)
D38457	NOVEMBER 26, 1999

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): N. LOYAL MD 3801 INTERNATIONAL DR, SILVER SPRING, MD 20906

State Registrar

31. Dete filed (Month, Dey, Yeer)	32. Registrer's Signeture
NOV 26 1999	▶ Renee G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39768

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Niklay Sayadian
2. Dete of Deeth Month / Dey / Yeer: November 27, 1999
3. Time ot Death: 9:30pm
4a. Feciity Name *(If not institution, give street and number)*: Layhill Health Center
4b. City, Town, or Location of Deeth: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 212-51-1610
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: MAr. 27, 1923
9. Birthpiece *(State or Foreign Country)*: Russia

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Montgomery Village
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 20504 Dubois Court
10f. Zip Code: 20886
10g. Citizen of Whet Country?: United States

11. Meritel Status: 1☐ Never Merried 2☒ Merried 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - Americen Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Owner
16b. Kind of Business/Industry: Shoe Store

17. Father's Neme *(First, Middle, Last)*: Bagrad Sayadian
18. Mother's Neme *(First, Middle, Maiden Surname)*: Miriam Hakopian

19a. Intormant's Name/Reietionship *(Type, Print)*: Albert Sayadian (Son)
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 20504 Dubois Court, Montgomery Village, MD 20886

20e. Method ot Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel trom Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Gate of Heaven Cemetery
Date: 12/01/99
20c. Location - City or Town, Stete: Silver Spring, MD

21. Signature of Funeral Service Licensee: Robert F. DeVol
22. Neme end Address ot Feciity: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in deeth): e. Respiratory Failure

Due to (or as a consequence ot):

Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Last:
b. Cerebro-Vascular Accident
Due to (or es e consequence of):
c. Guillan-Barre' Syndrome
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy tindings eveileble prior to completion ot cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medicel examiner? 1☐ Yes 2☒ No
26. Place ot Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred
28e. Place of Injury - At home, term, street, tectory, office building, etc. *(Specify)*
28i. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, date end ptece, end due to the ceuse(s) and menner stated.

29b. Signature end title of certifier
29c. License number: D34722
29d. Date signed *(Month, Day, Year)*: November 29, 1999

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print): Vicken Poochikian, M.D. 5632 Annapolis Road #3, Bladensburg, MD 20710

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: NOV 30 1999
32. Registrar's Signeture: Donna G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

ORIGINAL

99-7066-510
DDG
GEORGE SCHATZ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39769

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GEORGE FREDERICK SCHATZ
2. Date of Death (Month, Day, Year): NOVEMBER 26, 1999
3. Time of Death: 0953 AM
4a. Facility Name (If not institution, give street and number): ST. AGNES HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: NONE

Funeral Director

5. Social Security Number: 216-60-2254
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 46 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 9, 1953
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.
10b. County: PRINCE GEORGES
10c. City, Town or Location: RIVERDALE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 5310 TAYLOR RD.
10f. Zip Code: 20737
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): COURIER
16b. Kind of Business/Industry: PRIVATE

17. Father's Name (First, Middle, Last): WALTER SCHATZ SR.
18. Mother's Name (First, Middle, Maiden Surname): KATHRYN LOUISE McCANDLESS

19a. Informant's Name/Relationship (Type, Print): ANNE ABEL SCHATZ/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ITEM #10

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CHAMBERS CREMATORY
Date: 12/1/99
20c. Location - City or Town, State: RIVERDALE, MD.

21. Signature of Funeral Service Licensee: W.W. Chambers MO0091
22. Name and Address of Facility: CHAMBERS FUNERAL HOMES,P.A., RIVERDALE, MD. 20737

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Multiple Injuries
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): 11-26-99
28b. Time of Injury: 0810 M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how Injury occurred: driver auto - bus - collision
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Roadway
28f. Location (Street and Number or Rural Route Number, City or Town, State): I 95

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): NOVEMBER 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 02 1999
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39770

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Grace Irene Sells

2. Date of Death (Month, Day, Year): November 24, 1999

3. Time of Death: 7:00am

4a. Facility Name (If not institution, give street and number): 3308 Weller Road

4b. City, Town, or Location of Death: Wheaton

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-28-5292

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 12, 1921

9. Birthplace (State or Foreign Country): Virginia

Usual Residance of Decedant

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Wheaton

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3308 Weller Road

10f. Zip Code: 20906

10g. Citizan of Whet Country?: USA

11. Maritel Stetus: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Yaar or Datas:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elemantary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): Telephone Operator

16b. Kind of Businass/Industry: Federal Reserve Board

17. Fether's Nema (First, Middle, Last): Berkley Estes Wigglesworth

18. Mother's Name (First, Middle, Maiden Surname): Florence Wiley

19a. Informant's Name/Relationship (Type, Print): Linda L. Rosier/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3308 Weller Road, Wheaton, MD 20906

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Nama of cematary, crematory or other place): Fort Lincoln Cemetery | Date: Nov 29 1999

20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: Scott LeSmith

22. Nama and Address of Facility: Francis J.Collins Funeral Home, Inc. 500 University Blvd., W. Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on aach line.

		Approximate Interval Between Onset and Death
Immediate Causa (Final diseese or condition resulting in death) a.	Cancer of the Breast	8 years
Due to (or as a consequance of):		
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Causa (Disease or Injury that initieted events resulting in death) Last b.		
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension, Congestive Heart Failure

23b. Did tobacco uaa contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yas 2☒ No

24b. Ware eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa rafarred to medical examiner? 1☐ Yas 2☒ No

26. Place of Death (Chack only ona): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledga, death occurred at the tima, date and place, and due to the causa(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael R. Dobridge MD

29c. License number: D0 11388

29d. Date signed (Month, Day, Year): November 26, 1999

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Michael R. Dobridge MD 13975 Connecticut Ave. Silver Spring MD 20906

State Registrar

31. Data filed (Month, Day, Year): NOV 29 1999

32. Registrar's Signatura: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39771

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alan Silverberg

2. Data of Death — Month: December Day: 01 Year: 1999

3. Time of Death: 0507

4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 220.90.1163

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 22 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): 08.11.1977

9. Birthplace (State or Foreign Country): WASHINGTON, DC

Usual Residance of Decedent

10a. State: MD

10b. County: MONTGOMERY

10c. City, Town or Location: ROCKVILLE

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 1506 WEST KERSEY LANE

10f. Zip Code: 20854

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☒ Navar Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexicen, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - Amarican Indian, Black, White, atc. Specify: WHITE

15. Decedant's Educetion (Specify only highast grada completed) — Elamantary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): STOCK PERSON

16b. Kind of Business/Industry: RETAIL

17. Fathar's Name (First, Middla, Last): LARRY SILVERBERG

18. Mother's Nama (First, Middle, Meiden Surname): LYNN GOLDBERG

19a. Informent's Name/Ralationship (Type, Print): LYNN SILVERBERG/MOTHER

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 1506 WEST KERSEY LANE, ROCKVILLE, MARYLAND 20854

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Nama of cemetery, cremetory or other piece): JUDEAN MEMORIAL GARDENS

Dete: 12.2.99

20c. Location - City or Town, Steta: OLNEY, MARYLAND

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only ona ceuse on aach lina.

Approximate Interval Between Onset and Death

Immediata Causa (Final disaasa or condition resulting in death)

a. overwhelming sepsis — 48 hours

Dua to (or as a consequence of):

Sequantially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disaasa or Injury that Initiated evants resulting in daath) Last

b. chronic neutropenia — years

Dua to (or as a consequence of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Was cesa referred to medicel examinar? 1☐ Yas 2☒ No

26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Mannar of Death: 1☒ Neturel 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

29a. Certifiar (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examinetion and/or investigetion, in my opinion, death occurred at the tima, date and place, and due to the ceuse(s) and manner steted.

29b. Signatura and titla of certifiar: ▶ Robert L Fox MD

29c. License number: D 24773

29d. Data signed (Month, Day, Year): December 01, 1999

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print): Robert L. Fox, M.D. 9715 Medical Center Drive, Rockville, md.

State Registrar

31. Date filed (Month, Day, Year): DEC 02 1999

32. Registrar's Signatura: Bruce G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiena.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours aftar death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39772

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN T. SIMONS

2. Date of Death (Month, Day, Year): NOVEMBER 24, 1999

3. Time of Death: 10:00 A.M.

4a. Facility Name (If not institution, give street and number): HILLHAVEN NURSING CENTER

4b. City, Town, or Location of Death: ADELPHI

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 578-03-3102

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCT. 10, 1912

9. Birthplace (State or Foreign Country): WASHINGTON, DC

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: SILVER SPRING

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1131 CRESTHAVEN DRIVE

10f. Zip Code: 20903

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MANAGER

16b. Kind of Business/Industry: DEPT. OF TRANSPORTATION

17. Father's Name (First, Middle, Last): ALBERT J. SIMONS

18. Mother's Name (First, Middle, Maiden Surname): DELILAH BOSS

19a. Informant's Name/Relationship (Type, Print): RUTH SIMONS/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1131 CRESTHAVEN DRIVE SILVER SPRING, MD 20903

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GATE OF HEAVEN | Date: 11/27/99

20c. Location - City or Town, State: SILVER SPRING, MD

21. Signature of Funeral Service Licensee: Walter S. DiMeo

22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MD 20904

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA — 10 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Charles M Bonner

29c. License number: D31563

29d. Date signed (Month, Day, Year): November 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles M Bonner 11251 Lockwood Drive, Silver Spring, MD 20901

State Registrar

31. Date filed (Month, Day, Year): NOV 26 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39773

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LaVerne Margaret Smith
2. Dete of Deeth: Month November Dey 24 Yeer 1999
3. Time of Deeth: 17:57
4e Feclity Neme (If not institution, give street end number): Montgomery General Hospital
4b. City, Town, or Location of Deeth: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 569-54-7975
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthdey): 80 Yrs. If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): May 11 1919
9. Birthplece (Stete or Foreign Country): California

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Sandy Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 16800 Lehigh Drive
10f. Zip Code: 20860
10g. Citizen of Whet Country?: United States
11. Marital Stetus: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Fether's Neme (First, Middle, Last): Alfonse Maillard
18. Mother's Name (First, Middle, Maiden Surneme): Katherine Riordan
19a. Informent's Name/Reletionship (Type, Print): Bonnie J. Gilchrist/Daughter
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 16800 Lehigh Drive, Sandy Spring, Maryland 20860
20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other piece): Gate of Heaven Cemetery Dete: 11/30/99
20c. Locetion - City or Town, Stete: Silver Spring, Maryland
21. Signature of Funerel Service Licensee: ▶ Muriel H. Barber
22. Neme end Address of Fecility: Muriel H. Barber Funeral Home, P. O. Box 5038, Laytonsville, Maryland 20882

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Deeth

Immediate Cause (Finel diseese or condition resulting in death)
e. Respiratory failure — 2 days
Due to (or es e consequence of):
b. Aspiration Pneumonia — 3 days
Due to (or as a consequence of):
Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Lest
c. Haemorrhgic Stroke — 3 weeks
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert i.
Diabetes mellitus
Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner as stated. 2☐ **Medical Examiner:** On the besis of exemination end/or investigation, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) end menner steted.
29b. Signature end title of certifier: ▶ Amendhiratta
29c. License number: D38262
29d. Date signed (Month, Dey, Yeer): Nov 25, 1999
30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Dr A Mendhiratta 2401 Research BLVD Suite 340 Rockville MD 20854

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

State Registrar

31. Dete filed (Month, Dey, Yeer): NOV 30 1999
32. Registrer's Signeture: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39774

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ina C. Spaner

2. Date of Death (Month, Day, Year): November 26, 1999

3. Time of Death: 10:17 A.M.

4a. Facility Name (If not institution, give street and number): 4 Tapiola Court

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 320-16-4270

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 24, 1917

9. Birthplace (State or Foreign Country): Illinois

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4 Tapiola Court

10f. Zip Code: 20850

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates: X

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 4 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Professional Assoc.

17. Father's Name (First, Middle, Last): Carl Johan Holmberg

18. Mother's Name (First, Middle, Maiden Surname): Agnes Bäckström

19a. Informant's Name/Relationship (Type, Print): Kevin G. Spaner - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3643 Buckeye Court, Fairfax, Virginia 22033

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National | Date: 11/30/1999

20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: ▶ Donald C. Stottlemyer

22. Name and Address of Facility: Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland 20852

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Acute Respiratory Failure — Minutes

Due to (or as a consequence of): b. Metastatic Breast Cancer — Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: ▶ Donna Rinis MD

29c. License number: D28135

29d. Date signed (Month, Day, Year): 11/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Donna Rinis, M. D. 6000 Executive Blvd., # 300, Rockville, Maryland 20852

State Registrar

31. Date filed (Month, Day, Year): NOV 26 1999

32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39775

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: LILLIAN T. SPITTLE

2. Date of Deeth — Month: DECEMBER Day: 1 Year: 1999

3. Time of Deeth: 1:00AM

4a Facility Neme *(If not institution, give street and number)*: MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death: OLNEY

4c. County of Deeth: MONTGOMERY

Funeral Director

5. Social Security Number: 577-14-3507

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: FEB. 2, 1908

9. Birthplece *(State or Foreign Country)*: WASHINGTON, DC

Usual Residence of Decedent

10e. Stete: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: SILVER SPRING

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2601 BEL PRE ROAD

10f. Zip Code: 20906

10g. Citizen of Whet Country?: UNITED STATES

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Raca - American Indian, Bleck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 — College (1-4or 5+):

16e. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: CLERK

16b. Kind of Business/Industry: FEDERAL GOVERNMENT

17. Father's Name *(First, Middle, Last)*: JOHN W. TALBOTT

18. Mother's Name *(First, Middle, Maiden Surneme)*: LULA FLETCHER

19a. Informant's Neme/Relationship *(Type, Print)*: LENORE W. PHILLIPS/POA

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 7600 GEORGIA AVE. NW SUITE 402 WASHINGTON,DC20012

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CEDAR HILL CEMETERY

Dete: 12/3/99

20c. Location - City or Town, State: SUITLAND, MD

21. Signature of Funeral Service Licensee: Anthony L. DiMaio

22. Name end Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904

Physician /Medical Examiner

23e. Pert1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in deeth): e. Pneumonia — 4 days

Due to (or es a consequence of): b. Dehydration — 4 days

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest

Due to (or as a consequence of): c.

Due to (or es e consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospitel: 1☑ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Menner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end piece, end due to the ceuse(s) and menner stated.

29b. Signeture and title of certifier: Christopher J. Mays

29c. License number: D39793

29d. Date signed *(Month, Day, Year)*: December 1, 1999

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Christopher J. Mays, M.D. 12602 Georgia Ave. Wheaton MD 20902

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 02 1999

32. Registrer's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. **Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39776

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SARA EMILY STUTTE
2. Date of Death (Month, Day, Year): NOVEMBER 26, 1999
3. Time of Death: 2:02 P.M.
4a. Facility Name (If not institution, give street and number): HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: N/A
6. Sex: 1☐ M XX F
7. Age (In yrs. last birthday): Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.: 2
8. Date of Birth (Month, Day, Year): NOV. 26, 1999
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: BURTONSVILLE
10d. Inside City Limits: 1☐ Yes XX No
10e. Street and Number: 3901 BLACKBURN LANE, APT. #43
10f. Zip Code: 20866
10g. Citizen of What Country?: UNITED STATES OF AMERICA

11. Marital Status: XX Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes XX No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: ASIAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): RICHARD JAMES STUTTE
18. Mother's Name (First, Middle, Maiden Surname): YOON KYOUNG PAE

19a. Informant's Name/Relationship (Type, Print): RICHARD J. STUTTE (FATHER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3901 BLACKBURN LANE, APT. #43, BURTONSVILLE, MD 20866

20a. Method of Disposition: 1☐ Burial XX Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): FORT LINCOLN CREMATORY
Date: DEC. 02, 1999
20c. Location - City or Town, State: BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee: James J. Schwartz
22. Name and Address of Facility: HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MARYLAND 20904-2891

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PRETERM BIRTH
Due to (or as a consequence of):
b. NONVIABLE 21 WEEK FETUS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. POSSIBLE CERVICAL INCOMPETENCE
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M. Heather Sine MD
29c. License number: D52464
29d. Date signed (Month, Day, Year): NOVEMBER 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. Heather Sine MD 10313 Georgia Ave #20 Silver Spring, Md 20902

State Registrar

31. Date filed (Month, Day, Year): DEC 02 1999
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39777

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mathavam Subramaniam
2. Date of Death (Month, Day, Year): November 24, 1999
3. Time of Death: 1:00 PM
4a. Facility Name (If not institution, give street and number): 5340 Chase Lions Way
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 216-15-1963
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): September 22, 1919
9. Birthplace (State or Foreign Country): Sri Lanka

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5340 Chase Lions Way
10f. Zip Code: 21044
10g. Citizen of What Country?: Sri Lanka

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indian, Black, White, etc. Specify: Asian Indian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Appapillai Harischandra
18. Mother's Name (First, Middle, Maiden Surname): Indra (Unknown)

19a. Informant's Name/Relationship (Type, Print): Qumar Ravindran/ Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5340 Chase Lions Way Columbia, Maryland 21044

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): Chesapeake Crematory, Inc.
Date: 11/27/99
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: ▶Laura C. Hardesty
22. Name and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Drive Baltimore, Maryland 21286

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. (Approximate Interval Between Onset and Death)

Immediate Cause (Finel disease or condition resulting in death)
a. MYOCARDIAL INFARCTION
Due to (or as a consequence of):
b. HYPERTENSION
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. VASCULAR STROKES (TIAs)
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☑ No

25. Was cese referred to medicaf examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete and placa, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶RamaShankar MD
29c. License number: D0048046
29d. Date signed (Month, Day, Year): 11-24-99

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): RAMASHANKAR, 201-109 BACKRIVERNECKRd, Ba, MD 21221

State Registrar

31. Date filed (Month, Day, Year): NOV 26 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39778

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John James Svingos

2. Date of Death: Month 11 Day 22 Year 99

3. Time of Death: 12:25a.m.

4a. Facility Name (If not institution, give street and number): 11549 Glenarm Road

4b. City, Town, or Location of Death: Glenarm

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-60-8589

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 46 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct.26,1953

9. Birthplace (State or Foreign Country): Baltimore, MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Glenarm

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 11549 Glenarm Road

10f. Zip Code: 21057

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elamantary/Secondary (0-12): 12 | College (1-4or 5+): 5+

16a. Decedent's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT use retired): Music Teacher

16b. Kind of Business/Industry: Board of Education

17. Fether's Neme (First, Middle, Last): James John Svingos

18. Mother's Neme (First, Middle, Maiden Surneme): Helen Evangelinos

19a. Informent's Name/Reletionship (Type, Print): Hollyn Emerson-Svingos(wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11549 Glenarm Rd. Baltimore, MD 21057

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Name of cemetary, cramatory or other piece): Chesapeake Crematory

Dete: 11-26-99

20c. Location - City or Town, Stete: Beltsville, Maryland

21. Signeture of Funeral Service Licensee: Carola Dehn

22. Name and Address of Facility: Rapp Funeral & Cremation Services, Stephen D. Lohrmann, PA 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complicetions thet caused the death. Do not enter the mode ot dying, such es cardiac or respiratory arrest, shock, or heert feilure. List only one cause on eech lina.

Approximata Intervel Between Onset end Death

Immediata Ceuse (Finel disease or condition resulting in death)

a. Pancreatic Cancer — Approximata Intervel: 13months

Due to (or es a consequance of):

Sequentially list conditions, if eny, leading to immadiate cause. Entar Underlying Causa (Disease or Injury thet initieted events resulting in death) Lest

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Othar (Specify)

27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Panding investigetion 6 [ ] Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at tha time, data and place, and due to the cause(s) end mennar as stated. 2 [ ] **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred et tha time, data end place, and due to the cause(s) and mennar steted.

29b. Signature and title of certifier: Ross C. Donehower, MD DIRECTOR, MEDICAL ONCOLOGY

29c. License number: D23675

29d. Date signed (Month, Day, Year): November 23, 1999

30. Name and address of person who completed cause of death (Item 29a) (Type, Print): Johns Hopkins Hospital Ross C. Donehower, MD

State Registrar

31. Dete filed (Month, Day, Year): NOV 29 1999

32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth end Mentel Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vitai Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39779

Amend #23a.Part 1.Per Phys. PGC 12-2-99 cr

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William A. Thomas
2. Date of Death (Month, Day, Year): NOV. 21 1999.
3. Time of Death: 2:30 PM
4a. Facility Name (If not institution, give street and number): Golden Oaks Nursing Center.
4b. City, Town, or Location of Death: Laurel
4c. County of Death: P.G.

Funeral Director

5. Social Security Number: 578-22-2679
6. Sex: 1 X M 2 F
7. Age (In yrs, last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10/11/11
9. Birthplace (State or Foreign Country): Brewerville Liberia
Usual Residence of Decedent
10a. State: DC
10b. County: N/A
10c. City, Town or Location: Washington
10d. Inside City Limits: 1 X Yes 2 No
10e. Street and Number: 3900 16Th St NW #516
10f. Zip Code: 20011
10g. Citizen of What Country?: USA
11. Marital Status: **SINGLE** 1 Never Married 2 Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No ARMY If Yes, Give Year or Dates: 1942-45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 Years; College (1-4or 5+): 4 Years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Government Employee
16b. Kind of Business/Industry: GSA
17. Father's Name (First, Middle, Last): William H. Thomas
18. Mother's Name (First, Middle, Maiden Surname): Cora Pair
19a. Informent's Name/Relationship (Type, Print): David Thomas (Brother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5250 Valley Forge Drive., Alexandria, Va., 22304
20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetary, cremetory or other place): Md Nat'L Mem Park Cem
Data: 11/27/99
20c. Location - City or Town, State: Laurel, Md.
21. Signature of Funeral Service Licensee: Juan Smith CC0273
22. Name and Address of Facility: John T. Rhines Co., Inc. 3030 12th Street NE, DC 20017

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failure. List only ona causa on aach lina.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Cardio pulmonary failure
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last
b. Syncope & Chronic Cerbellar Infarct
Dua to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No

25. Was case referred to medical examiner? 1 Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify)
27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 Yes 2 X No
28d. Describe how injury occurred: N / A
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kaman
29c. License number: D0053709
29d. Date signed (Month, Day, Year): 11/28/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KAJ Kumar Chawla Bowie MD

State Registrar

31. Date filed (Month, Day, Year): NOV 3 0 1999
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

3

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39780

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Harry Walker THOMAS
2. Date of Death: Month Dec. Day 6 Year 1999
3. Time of Death: 1140
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 217-28-1512
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 18 1932
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Pa.
10b. County: Franklin
10c. City, Town or Location: Greencastle
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 14812 Sherwood Drive
10f. Zip Code: 17225
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Korean
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0-12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Field Supervisor
16b. Kind of Business/Industry: Shoe Company
17. Father's Name (First, Middle, Last): Harry Ira Thomas
18. Mother's Name (First, Middle, Maiden Surname): Frances Smith
19a. Informant's Name/Relationship (Type, Print): Patricia A. Thomas
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14812 Sherwood Drive Greencastle, Pa. 17225
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rest Haven Cemetery
Date: 12/10/99
20c. Location - City or Town, State: Hagerstown, Maryland
21. Signature of Funeral Service Licensee: Scott M. Minnich
22. Name and Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. acute myocardial infarction, Complicated — 6-8 hrs.
Due to (or as a consequence of):
b. nicotine addiction — 50-60 yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. advanced emphysema
Due to (or as a consequence of):
d. morbid obesity

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Dan H. McDonagh
29c. License number: D 21470
29d. Date signed (Month, Day, Year): 12/7/99
30. Name and address of person who completed cause of death (Item 29a) (Type, Print): DAN McDONAGH, MD WASH CO. HOSP.

State Registrar

31. Date filed (Month, Day, Year): DEC 08 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Thomas, Harry

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39781

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Terry Arnold TOMS

2. Date of Death (Month, Day, Year): November 26 1999

3. Time of Death: 2345

4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 218-50-2513

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 47 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 18, 1951

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Williamsport

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 30 East Church Street

10f. Zip Code: 21795

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 0-12 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cab Driver

16b. Kind of Business/Industry: Taxie Company

17. Father's Name *(First, Middle, Last)*: Maurice W. Toms

18. Mother's Name *(First, Middle, Maiden Surname)*: Janice A. Wolfe

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Janice A. Viertel/mother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 30 East Church Street, Williamsport, Maryland 21795

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hagerstown Crematory

Date: Nov. 29,1999

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Robert E Clem

22. Name and Address of Facility: Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. UREMIC ENCEPHLOPATHY — One wk

Due to (or as a consequence of):
b. LIVER FAILURE — Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. CIRRHOSIS — Unknown

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D44996

29d. Date signed *(Month, Day, Year)*: NOV. 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Zafar Malik MD 20311 Leppans Rd Boonsboro, MD 21713

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 29 1999

32. Registrar's Signature: G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Toms, Terry

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39782

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Hall Trotter SR.

2. Date of Death Month Day Year: November 25, 1999

3. Time of Death: 9:24 PM

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 242-18-1991

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): August 31, 1921

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Virginia

10b. County: City

10c. City, Town or Location: Alexandria

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 403 Fontaine Street

10f. Zip Code: 22302

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 8

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): International Trade Specialist

16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Millard F. Trotter

18. Mother's Name (First, Middle, Maiden Surname): Lois Hall Henderson

19a. Informant's Name/Relationship (Type, Print): William H. Trotter Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16223 Woburn Rd. Sharpsburg, Maryland 21782

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Prebyterian Cem. Of Oldtown

Date: 11-30-99

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Scott E. Osborne

22. Name and Address of Facility: Osborne Funeral Home 425 South Conococheague St. Williamsport, Maryland 21795

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA — 1 WEEK

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Last

b.

Due to (or es e consequence ot):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dehydration, Atherosclerotic heart Disease, Hypertension, Coronary Artery Disease. Cerebrovascular accident

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D44996

29d. Date signed (Month, Day, Year): NOV. 28, 1999

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): ZAFAR MALIK MD 20311 Lappans Road Boonsboro, MD 21713.

State Registrar

31. Date filed (Month, Day, Year): NOV 29 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39783

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Louis Ferrel TURNER

2. Date of Death (Month, Day, Year): November 24, 1999

3. Time of Death: 11:11 pm

4a. Facility Name *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-09-0891

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 20 1918

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland — 10b. County: Washington — 10c. City, Town or Location: Hagerstown — 10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 11900 Turners Lane — 10f. Zip Code: 21742 — 10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: W.W. II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No — Specify:

14. Race - American Indian, Black, White, etc. — Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: Bread Distribution

17. Father's Name *(First, Middle, Last)*: Amos Turner

18. Mother's Name *(First, Middle, Maiden Surname)*: Alice Mae Baker

19a. Informant's Name/Relationship *(Type, Print)*: Pearl Turner - Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11900 Turners Lane Hagerstown, Md. 21742

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Rest Haven Cemetery — Date: 11/27/99

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott Minnich

22. Name and Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Peritonitis — Approximate Interval: Days

Due to (or as a consequence of):
b. Perforated Peptic ulcer — Approximate Interval: Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

Chronic obstructive pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Date of Injury *(Month, Day Year)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D21457

29d. Date signed *(Month, Day, Year)*: 11-25-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ABDUL WAHEED MD-12821-OAK HILL AVE. HAGERSTOWN. MD

State Registrar

31. Date filed *(Month, Day, Year)*: NOV 29 1999

32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Turner, Louis Ferrel

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39784

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donald Fred Tracey, Sr.

2. Date of Death: Month November Day 29 Year 1999

3. Time of Death: 6:05 p.m.

4a. Facility Name (If not institution, give street and number): Fallston General Hospital

4b. City, Town, or Location of Death: Fallston

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 218-40-1364

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 56 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): August 7, 1943

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 1014 Prospect Mill Rd.

10f. Zip Code: 21015

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Meat Merchandiser

16b. Kind of Business/Industry: Food Distributor

17. Father's Name (First, Middle, Last): Fred (u/k) Tracey

18. Mother's Name (First, Middle, Maiden Surname): Susan (u/k) Pryor

19a. Informant's Name/Relationship (Type, Print): Georgia A. Tracey/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1014 Prospect Mill Rd, Bel Air, MD 21015

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Highview Memorial Gardens

Date: 12-4-99

20c. Location - City or Town, State: Fallston, Maryland

21. Signature of Funeral Service Licensee: Donald K. McComas

22. Name and Address of Facility: McComas Funeral Home, P.A. 50 W. Broadway Street, Bel Air, MD 21014

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ESOPHAGEAL CANCER — 3 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: R. Phillips

29c. License number: D 22843

29d. Date signed (Month, Day, Year): November 29 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): R. PHILLIPS 2005 RICE SPRING MD FOREST HILL MD 21050

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Donald Tracey

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39785

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOYCE EILEEN TALBERT

2. Date of Death (Month, Day, Year): NOVEMBER 30, 1999

3. Time of Death: 7:55 PM

4a. Facility Name (If not institution, give street and number): SUBURBAN HOSPITAL

4b. City, Town, or Location of Death: BETHESDA

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 213-24-9292

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar 15, 1928

9. Birthplace (State or Foreign Country): Maryland

Usual Residance of Decedant

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Derwood

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7625 Dew Wood Drive

10f. Zip Code: 20855

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse

16b. Kind of Business/Industry: Health Care

17. Father's Name (First, Middle, Last): David Paul Shilling

18. Mother's Name (First, Middle, Maiden Surname): Florence Emma Wolfinger

19a. Informant's Name/Relationship (Type, Print): Thomas V. Talbert, husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7625 Dew Wood Drive, Derwood, MD 20855

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removel from State 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Funkstown Cemetery

Data: Dec 4, 1999

20c. Location - City or Town, State: Funkstown, Maryland

21. Signature of Funeral Service Licensee: ▶ Curtis E. Day

22. Name and Address of Facility: DeVol Funeral Home 10 E. Deer Park Drive, Gaithersburg, MD 20877

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. VENTRICULAR FIBRILLATION — 7 DAYS

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE — 5 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

TALBERT, JOYCE S 11/30/99 7:55PM

12

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Virginia Callwer MD

29c. License number: 54597

29d. Date signed (Month, Day, Year): NOVEMBER 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VIRGINIA CALLWER 6410 ROCKLEDGE DRIVE SUITE 200 BETHESDA MD 20817

State Registrar

31. Data filed (Month, Day, Year): DEC 03 1999

32. Registrar's Signature: ▶ Penny G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39786

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Pamela Scott Terry
2. Date of Death: Month November Day 30, Year 1999
3. Time of Death: 5:25 AM
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: None

Funeral Director

5. Social Security Number: 229-86-8173
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 42 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 10, 1957
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: VA
10b. County: Macklenburg
10c. City, Town or Location: Clarksville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2400 Shiny Rock Road
10f. Zip Code: 21203
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 4+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Willie Scott
18. Mother's Name (First, Middle, Maiden Surname): Lillie Tucker

19a. Informant's Name/Relationship (Type, Print): Chester W. Terry Sr. - Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2400 Shiny Rock Road Clarksville, VA 21203

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Douglas Ch. Cemetery — Date: Dec. 4, 1999
20c. Location - City or Town, State: Boydton, Virginia

21. Signature of Funeral Service Licensee: Allen J. Woodall
22. Name and Address of Facility: Metropolitan Funeral Service, Inc. 5517 Vine Street Alexandria, VA 22310

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Breast Cancer	7 years
Due to (or as a consequence of):	b. Adriamycin Induced Cardiomyopathy	1 1/2 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Asthma	25 years
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Anemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Cynthia Brown, MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): 11/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Cynthia Brown, MD The Johns Hopkins Hospital, 600 N. Wolfe St, Tower 110, Baltimore, MD

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39787

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARIE S. THURMOND

2. Date of Death (Month, Day, Year): December 1, 1999

3. Time of Death: 5:30 am

4a. Facility Name (If not institution, give street and number): Holy Cross Rehabilitation & Nursing Center

4b. City, Town, or Location of Death: Burtonsville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-09-3775

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jun 25, 1911

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 14400 Homecrest Road #251

10f. Zip Code: 20906

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Seginak

18. Mother's Name (First, Middle, Maiden Surname): Martha Gerchak

19a. Informant's Name/Relationship (Type, Print): Marianne T. Kearns / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2825 Southwest Dukeries Road, Topeka, KS 66614

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National Cemetery

Date: 12/10 1999

20c. Location - City or Town, State: Arlington, VA

21. Signature of Funeral Service Licensee: ▶ TRACY A. STUVER

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS	2 weeks
Due to (or as a consequence of):	b. PNEUMONIA	2 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. MALNUTRITION	2 months
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Paul Armstrong

29c. License number: D43237

29d. Date signed (Month, Day, Year): December 1, 1994

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): PAUL ARMSTRONG MD 14201 LAUREL PK DR #102 LAUREL MD 20707

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999

32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39788

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Dete of Deeth Month Day Year	3. Time of Death
George	Melvin	Townsend	November 28, 1999	8:40P.

4a. Feciility Name (If not institution, give street end number)	4b. City, Town, or Location of Deeth	4c. County of Death
Doctor's Community Hospital	Lanham	Prince George's

Funeral Director

5. Sociel Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplece (State or Foreign Country)
579-38-5587	XX 1 M 2 F	71 Yrs.			June 7, 1928	Pennsylvania

Usual Residenca of Decedent

10a. Stete	10b. County	10c. Cify, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Greenbelt	1 X Yes 2 No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
51 D Ridge Road	20770	United States

11. Marital Stetus	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	XX Yes 2 No If Yes, Give Year or Dates: 1946-1952	1 Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grede completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12): 11	College (1-4or 5+)	Electronic Technician	U.S. Postal Service

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surneme)
Richard E. Townsend	Alberta Weimer

19a. Informent's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
Louvain C. Townsend (wife)	same as #10

20a. Method of Disposition	20b. Placa of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Resurrection Cemetery	12/2/1999	Clinton, Maryland

21. Signature of Funeral Service Licensee: Donald V. Borgwardt

22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only* one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Finel diseese or condition resulting in death)	a. Congestive Heart failure	years
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Lest	Due to (or as a consequence of): b. Coronary artery disease.	years.
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive Pulmonary disease

23b. Did tobecco uee contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24e. Was an autopsy performed?	24b. Were autopsy findings eveileble prior to completion of cause of deeth?
1 Yes 2 XX No	1 Yes 2 X No

25. Was case referred to medical exeminer?	26. Place of Deeth (Check only one)	
1 Yes 2 XX No	Hospital: XX 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residenca 6 Other (Specify)

27. Manner of Deeth	28e. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1 X Naturel 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): XX 1 **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and pleca, and due to the ceuse(s) end menner es stated.
2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the ceuse(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Dete signed (Month, Day, Year)
surinder singh	D28920 MD.	November 29, 1999

30. Name end address of person who completed ceuse of death (Item 23e) (Type, Print): Surinder Singh, M.D. 7319A Hanover Parkway Greenbelt, Maryland 20770

State Registrar

31. Dete filed (Month, Dey, Yeer)	32. Registrar's Signature
NOV 30 1999	Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39789

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Ida	Mae	Ustad	November	29,	1999	7:10 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Hebrew Home of Greater Washington	Rockville	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
504 62 9300	1☐ M 2☒ F	50 Yrs.					May 24, 1949	South Dakota

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1900 Lyttonsville Rd.	20910	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Procurment Specialist	Federal Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Gilbert Ustad	Mildred Johnson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Agnes Patti / Sister	7306 Holly Ave., Takoma Park, MD 20912

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Chesapeake Crematory Inc.	12/1/99	Beltsville, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Stephen D Lohrmann	Rapp Funeral and Cremation Services Stephen D. Lohrmann P.A. 933 Gist Ave., Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Sepsis	
	Due to (or as a consequence of):	
	b. Pelvic Abscess	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of):	
	c. CARCINOMA Bladder, metastatic	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Gregory A Compton MD	D24942	NOV 30 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GREGORY A. COMPTON MD 6121 Montrose Rd Rockville, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 01 1999	

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

20

DEC 0 1 1998

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39790

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Margaret Vanlaer

2. Date of Death: Month November Day 30 Year 1999

3. Time of Death: 11:10

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 219-64-0573

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 46 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 7, 1953

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Clear Spring

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 21 Cumberland Street

10f. Zip Code: 21722

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Educator

16b. Kind of Business/Industry: Private School

17. Father's Name (First, Middle, Last): Edwin R. Itnyre

18. Mother's Name (First, Middle, Maiden Surname): Lena Bradley

19a. Informant's Name/Relationship (Type, Print): Eric G. Vanlaer, Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 21 Cumberland Street, Clear Spring, Maryland 21722

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Smithsburg Crematory

Date: Dec. 1

20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: Kelly A. Zimmerman

22. Name and Address of Facility: Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N., Hagerstown, Maryland 21742

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Breast Cancer — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael J. McConnack MD

29c. License number: D41667

29d. Date signed (Month, Day, Year): 11-30-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael J. McConnack 11110 Medical Campus Rd. Suite 130 Hagerstown MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Vanlaer, Mary Margaret 3041005582

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39791

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Anne Virginia Valentine
2. Date of Death (Month, Day, Year): November 25, 1999
3. Time of Death: 7:33 pm
4a. Facility Name *(If not institution, give street and number)*: 129 Lexington Drive
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-05-8821
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 1, 1914
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 129 Lexington Drive
10f. Zip Code: 20901
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Price Hall
18. Mother's Name *(First, Middle, Maiden Surname)*: Grace Elizabeth Frye Hall

19a. Informant's Name/Relationship *(Type, Print)*: John H. Valentine
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 300 Dogwood Drive, Winchester, VA 22602

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Jackson Cemetery — Date: Nov 28 1999
20c. Location - City or Town, State: Mt. Jackson, VA

21. Signature of Funeral Service Licensee: J. Kevin Gale
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Myocardial Infarction — DMT

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD DME
29c. License number: D00428
29d. Date signed *(Month, Day, Year)*: Nov. 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): IRA N Brecher MD DME — 2101 Medical Park Dr Silver Spring MD 20902

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 01 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ADH
JOHN J. VIGNAU
99-7077-031

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39792

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John J. Vignau
2. Date of Death (Month, Day, Year): NOVEMBER 26, 1999
3. Time of Death: 1445 PM
4a. Facility Name (If not institution, give street and number): 404 NORTHWEST DRIVE
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 212-54-3587
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 49 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 19, 1950
9. Birthplace (State or Foreign Country): DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 401 Southwest Drive
10f. Zip Code: 20901
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Tree Trimmer
16b. Kind of Business/Industry: Landscaping

17. Father's Name (First, Middle, Last): John Alphonse Vignau
18. Mother's Name (First, Middle, Maiden Surname): Helen Burke

19a. Informant's Name/Relationship (Type, Print): George Berley/ Brother-in-law
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1969 Steeple Chase Pkwy., Rock Hill, SC 29732

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Resthaven Memorial Gardens
Date: 12/2/1999
20c. Location - City or Town, State: Frederick , MD

21. Signature of Funeral Service Licensee: Eva S. Scalo
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 Universtiy Blvd, W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Injuries
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) AT SCENE

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): 11-26-99
28b. Time of Injury: 1440 M
28c. Injury at Work? 1 [X] Yes 2 [ ] No
28d. Describe how injury occurred: Subject fell out of tree
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Yard
28f. Location (Street and Number or Rural Route Number, City or Town, State): 404 Northwest Drive

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: OCME
29d. Data signed (Month, Day, Year): NOVEMBER 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year): DEC 02 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39793

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ruth Newkirk Wanner
2. Date of Death Month Day Year: November 30, 1999
3. Time of Death: 4:35 p.m.
4a. Facility Name *(If not institution, give street and number)*: Magnolia Center Genesis ElderCare
4b. City, Town, or Location of Death: Lanham
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 331-01-9223
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 24, 1915
9. Birthplace *(State or Foreign Country)*: Illinois

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4905 77th Place
10f. Zip Code: 20784
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Datas:
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grada completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middla, Last)*: Claude Newkirk
18. Mother's Name *(First, Middle, Maiden Surneme)*: Eva Roberts

19a. Informant's Name/Relationship *(Type, Pnint)*: Howard G. Wanner
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4905 77th Place, Hyattsville, MD 20784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: Fort Lincoln Cemetery — Date: 12/03/99
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: ▶ Claudette L. Gasch
22. Nama and Address of Facility: Gasch's Funeral Home 4739 Baltimore Avenue, Hyattsville, MD 20781

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one ceuse on each line.

		Approximata Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in deeth) a.	Cardiopulmonary Arrest	1 hour
Due to (or as a consequence of):	Arteriosclerotic Cardiovascular Disease	2 months
Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.		
Due to (or es a consequence of): c.	Chronic Obstructive Lung Disease	8 years
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa given in Part I.

23b. **Did tobacco uas contributs to the cause of death?** 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Andres C. Lara, M.D.
29c. License number: D16197
29d. Date signed *(Month, Day, Year)*: December 1, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andres C. Lara, M.D. 9326 Lanham Severn Rd., Lanham, Maryland 20706-2775

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 02 1999
32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

DEC 02 1998

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39794

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Lois Wilburn

2. Date of Death Month Dey Yeer: November 30,1999

3. Time of Death: 3:05AM

4e. Facility Name *(If not institution, give street and number)*: Annapolis Colonial Manor Nursing Home

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 577-03-5432

6. Sex 1☐M 2☐F: X

7. Age *(In yrs. last birthdey)*: 89 Yrs. | If Under 1 Yeer: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Yeer)*: Sept 26, 1910

9. Birthplece *(Stete or Foreign Country)*: Maryland

Usual Residence of Decedent

10e. Stete: MD

10b. County: Queen Annes

10c. City, Town or Location: Stevensville

10d. Inside City Limits 1☐Yes 2☐No: XX

10e. Street and Number: 112 Eareckson Lane

10f. Zip Code: 21666

10g. Citizen of Whet Country?: United States

11. Meritel Status: 1☐Never Merried 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - Americen Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 8th | College (1-4or 5+): N/A

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Fether's Neme *(First, Middle, Last)*: Sumerseth Robey

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Mary King

19e. Informent's Name/Reletionship *(Type, Print)*: Adrienne F. Myers (DAUGHTER)

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 112 Eareckson Lane, Stevensville, Maryland 21666

20e. Method of Disposition 1☒Burial 2☐Cremetion 3☐Removel from State 4☐Donation 5☐Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Epiphany Episcopal Cemetery | Dec. 3, 1999

20c. Locetion - City or Town, Stete: Forestville, Maryland

21. Signeture of Funerel Service Licensee: [signature] M01095

22. Neme end Address of Facility: Lee Funeral Home,Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not antar the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset end Deeth

Immediate Ceuse (Finel disease or condition resulting in death)
e. Aspiration pneumonia
Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest
b. Dementia
Due to (or as a consequence of):
c. Parkinson's disease
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobecco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24e. Wes en autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings aveileble prior to completion of ceuse of deeth? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☐Yes 2☑No

26. Piece of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpetient 3☐DOA | Other: 4☑Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Menner of Deeth: 1☑Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Locetion *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑**Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐**Medical Examiner**: On the besis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: [signature] MD

29c. Licanse number: D 22028

29d. Date signed *(Month, Dey, Yeer)*: 12.1.99

30. Name end eddress of person who completed ceuse of deeth (item 23e) (Type, Print): Paul S. Rhodes, M.D. 1667 Crofton Ctr. Crofton, Maryland 21114

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: DEC 0 3 1999

32. Registrer's Signetura: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DEC 03 1998

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39795

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LOUISE WATKINS

2. Date of Death Month: 12 Day: 01 Year: 99

3. Time of Death: 10:45 am

4a Facility Name *(If not institution, give street and number)*: MAGNOLIA GARDENS NURSING HOME

4b. City, Town, or Location of Death: LANHAM

4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 579-70-1727

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: April 21, 1924

9. Birthplace *(State or Foreign Country)*: Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Landover

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2916 Brightseat Road

10f. Zip Code: 20785

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Thomas Wright

18. Mother's Name *(First, Middle, Maiden Surneme)*: Annie Norman

19a. Informant's Name/Relationship *(Type, Print)*: Amos Watkins/Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2916 Brightseat Road, Landover, Maryland 20785

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Harmony Memorial Park

Date: 12/07/1999

20c. Location - City or Town, Steta: Landover, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Nama and Address of Facility: J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused the death. Do not entar tha moda of dying, such as cardiac or raspiratory arrest, shock, or heert teilura. List only ona cause on eech line.

Approximata Intarval Batwean Onsat and Daath

Immediata Causa (Final diseasa or condition resulting in death)

a. TERMINAL CANCER OF THE COLON WITH METASTASIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last

b.

Dua to (or as a consequence of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

DIABETES MELLITUS

HYPERTENSION

PARTIAL BOWEL OBSTRUCTION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of causa of death? 1☐ Yas 2☐ No

25. Wes case refarred to medicat examiner? 1☐ Yas 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Homa 5☐ Residence 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Neturat 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, tarm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and dua to the cause(s) and mannar as stated. 2☐ **Medicat Examiner:** On tha basis of examination and/or investigation, in my opinion, deeth occurred et the time, data and piece, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier: Villamor S. Romos M.D.

29c. License number: D29671

29d. Data signed *(Month, Day, Year)*: 12/1/99

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): VILLAMOR S. ROMOS, M.D. 6501 LANDOVER RD Chevarly MD 20785

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 03 1999

Registrar's Signatura: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit area.

Medical Certification: To Be Completed by Physician/Medical Examiner

DEC 0 3 1992

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39796

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edna Mae Winburn
2. Date of Death Month Day Year: Nov 24,1999
3. Time of Death: 9:28 PM
4a. Facility Name *(If not institution, give street and number)*: Wash. Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579 14 3052
6. Sex: 1☐ M 2☒ F (XX)
7. Age *(In yrs. last birthday)*: 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 3, 1920
9. Birthplace *(State or Foreign Country)*: Washington DC

Usual Residence of Decedent

10a. State: MD
10b. County: P.G.
10c. City, Town or Location: Clinton
10d. Inside City Limits: 1☐ Yes 2☒ No (X)
10e. Street end Number: 8600 Mike Shapiro Road #516
10f. Zip Code: 20735
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced (X)
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No (XX) If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No (XX) *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: State Department
16b. Kind of Business/Industry: Federal Government

17. Father's Name *(First, Middle, Last)*: John Atkins
18. Mother's Name *(First, Middle, Maiden Surname)*: Allie Seay

19a. Informant's Name/Relationship *(Type, Print)*: Walter Winburn (SON)
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 6607 Forestview Drive, Arlington , TX 76016

20a. Method of Disposition: 1☒ Buriel (XX) 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Fort Lincoln Cemetery — Dete: Nov 25,1999
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Lee Funeral Home,Inc 6633 Old Alexandria Ferry Road, Clinton,Maryland 20735

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

CR

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset end Deeth

Immediete Ceuse (Finel disease or condition resulting in death)
e. CONGESTIVE CARDIOMYOPATHY

Due to (or as e consequence of):
b. CORONARY ARTERY DISEASE

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in deeth) Last

Due to (or as a consequence of):
c.

Due to (or as e consequence of):
d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.
ACUTE RENAL FAILURE
COMPLETE HEART BLOCK
MYOCARDIAL INFARCTION

23b. Did tobacco use contribute to the ceuse of deeth? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown (✓)

24a. Was en eutopsy performed? 1☐ Yes 2☒ No (✓)
24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No (✓)
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient (✓) 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural (✓) 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined (✓)
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) end manner as stated. (✓) 2☐ **Medical Examiner:** On the basis of exemination and/or Investigation, in my opinion, death occurred at the time, dete and piece, end due to the cause(s) end manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D 51096
29d. Date signed *(Month, Dey, Year)*: 11/25/99
30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print): PIOTR M WYRWINSKI, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

State Registrar

31. Date filed *(Month, Dey, Yeer)*: NOV 30 1999
32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39797

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
WILLIAM WALKER	11 / 26 / 99	11:40 am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
LAUREL REGIONAL HOSPITAL	LAUREL	PRINCE GEORGE'S

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
245-28-1708	1☒ M 2☐ F	72 Yrs.			January 24,1927	North Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Upper Marlboro	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9410 Croom Acres Drive	20772	U.S.A.

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Yeer or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Brick Mason	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Harold Walker	Esther Dove

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Blanche R. Walker/Wife	9410 Croom Acres Drive, Upper Marlboro, Maryland 20772

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)	Maryland National Cemetery	12/04 1999	Laurel, Maryland

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility
J.B. JENKINS FUNERAL HOME
7474 LANDOVER ROAD, LANDOVER,MARYLAND 20785

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximete Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Hypoxia	Few Mnts
Due to (or as a consequence of):	b. Respiratory Failure	Few mnts
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other signficant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

CVA

seizures.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and menner es stated.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signeture and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD attending.	D42580	11/30/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PARMJIT S AUJLA M.D. 5632 Annapolis Rd.#13, Bladensburg, Maryland 20710

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 0 1 1999	[signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DEC 01 1998

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39798

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Prudence Helen Wallace

2. Date of Death — Month: December Day: 4 Year: 1999

3. Time of Death: 07:45 PM

4a. Facility Name (If not institution, give street and number): Twin Oaks Retirement Village

4b. City, Town, or Location of Death: Williamsport

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 216-05-4321

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 17, 1917

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 17952 Garden Lane Apt.3

10f. Zip Code: 21740

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retirad): Housewife

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Peter Lesher Martin

18. Mother's Name (First, Middle, Maiden Surname): Helen Teresa Shank

19a. Informant's Name/Relationship (Type, Print): David H. Martin/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16224 Fairview Rd. Hagerstown,MD 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Plece of Disposition (Name of cemetery, cremetory or other place): Mt.Tabor Lutheran Cem.

Date: 12-7-99

20c. Location - City or Town, Stete: Fairview,Maryland

21. Signature of Funeral Service Licensee: Scott E. Osborne

22. Name and Address of Facility: Osborne Funeral Home,P.A. 425 S. Conococheague St.Williamsport,MD 21795

December 4, 1999

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE RENAL FAILURE — 2 WEEKS

Due to (or as e consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest

b. Due to (or as a consequence of):

c. Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PROGRESSIVE SENILE DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: TEHowe. MD

29c. License number: D33700

29d. Date signed (Month, Dey, Year): December 7, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TED E. HOWE 7542 OVERLOOK DRIVE, BOONSBORO, MD 21713

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Prudence Wallace.

State Registrar

31. Dete filed (Month, Dey, Year): DEC 07 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39799

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy Philamina Wahler

2. Date of Death (Month, Day, Year): NOVEMBER 30, 1999

3. Time of Death: 0645

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington County

Funeral Director

5. Social Security Number: 144-03-9288

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 23, 1918

9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: MD

10b. County: Washington Co.

10c. City, Town or Location: Williamsport

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4 Oak Tree Lane, Apt. G

10f. Zip Code: 21795

10g. Citizen of What Country? U.S.A.

11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+): 0

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Residence

17. Father's Neme (First, Middle, Last): Henry Michael Nissel

18. Mother's Neme (First, Middle, Maiden Sumeme): Lillian A. Ziegler

19a. Informent's Neme/Reletionship (Type, Print): Albert O. Wahler/Husband

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 4 Oak Tree Lane, Apt. G, Williamsport, MD 21795

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Greenlawn Memorial Park

Dete: Dec. 3

20c. Location - City or Town, Stete: Williamsport, Maryland

21. Signeture of Funeral Service Licensee: Kelly A. Zimmerman

22. Name end Address of Feclity: Douglas A. Fiery Funeral Home 1331 Eastern Blvd.,N.,Hagerstown,Maryland 21742

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complizations thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediete Cause (Finel diseese or condition resulting in deeth)

e. LUNG CARCINOMA - — YEARS

Due to (or es a consequence of):

b. METASTASIS TO OPPOSITE LUNG — MONTHS

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest

Due to (or es e consequence of):

c. AND BRAIN (CEREBELLUM)

Due to (or as a consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: COLON CARCINOMA -

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one) — Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physicten:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: WORCESTER MD

29c. License number: D22043

29d. Dete signed (Month, Day, Year): 11/30/99

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): 11110 MEDICAL CAMPUS RD #130 HAGERSTOWN, MD 21742

State Registrar

31. Dete filed (Month, Dey, Yeer): DEC 03 1999

32. Registrer's Signeture: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WAHLER, DOROTHY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39800

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Donald Gordon WISHARD

2. Data of Daath — Month: November; Day: 30; Yaar: 1999

3. Tima of Death: L;00 p.m.

4a. Facility Nama *(If not institution, giva street and number)*: Williamsport Nursing Home

4b. City, Town, or Location of Death: Williamsport

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 213-24-7500

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 69 Yrs.

If Under 1 Year — Months: ; Days: ; If Under 24 Hrs. — Hours: ; Min.:

8. Data of Birth *(Month, Day, Yaar)*: Feb. 5, 1930

9. Birthplaca *(Stata or Foreign Country)*: Maryland

Usual Residence of Decedant

10a. Stata: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 13147 Resh Road

10f. Zip Coda: 21740

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1☒ Yas 2☐ No If Yas, Giva Year or Datas: 1947-67

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Raca - American Indian, Black, Whita, atc. *Specify:* white

15. Decedant's Education *(Specify only highest greda compiated)*: Elamantary/Secondary (0-12): 12; Collaga (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: correctional officer

16b. Kind of Businass/Industry: prison

17. Fathar's Nama *(First, Middla, Last)*: Fred Henry Wishard, Sr.

18. Mother's Name *(First, Middla, Maidan Surname)*: Jennie Gordon

19a. Informant's Name/Ralationship *(Type, Print)*: Lloyd L. Waters - POA

19b. Mailing Address *(Street and Numbar or Rural Route Number, City or Town, Stata, Zip Code)*: 3421 Harpers Ferry Rd., Sharpsburg, Md. 21782

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of camatary, cramatory or other piece)*: Cedar Lawn Mem. Park

Data: 12-3-99

20c. Location - City or Town, Stete: Hagerstown, Maryland

21. Signeture of Funerel Sarvice Licensee: ▶ Fred L Wentz

22. Neme end Addrass of Facility: MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Wishard, Donald Gordon November 30, 1999 1 PM

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter tha disaasa, or complications that caused tha deeth. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximate Interval Batween Onset end Death

Immadiata Causa (Final diseasa or condition resulting in daath)

e. Lung Cancer — Approximate Interval: 1½ years

Dua to (or as a consequance of):

Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiated avants resulting in daath) Last

b.

Dua to (or as a consequance of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying cause given in Part I.

Hypertension

Peripheral Vascular Disease

23b. Did **tobacco use contribute to the cause of death?** 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy parformad? 1☐ Yas 2☒ No

24b. Wara autopsy findings availabla prior to completion of cause of daath? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examiner? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarminad

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describa how injury occurrad

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar steted.

29b. Signeture end title of certifiar: ▶ Cynthia Kuttner-Sands, MD

29c. Licansa number: D47451

29d. Date signed *(Month, Day, Yaar)*: December 3, 1999

30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print): Cynthia Kuttner-Sands, MD 11110 Medical Campus Road, Suite 130, Hagerstown, Maryland

State Registrar

31. Data filed *(Month, Day, Yaar)*: DEC 06 1999

32. Registrar's Signatura: G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39801

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decadant's Nama (First, Middle, Last): JOANIE CHARLENE WHEELER
2. Data of Death (Month, Day, Year): DECEMBER 2, 1999
3. Time of Deeth: 8:15AM

4a. Facility Nama (If not institution, giva street and number): CIVISTA MEDICAL CENTER
4b. City, Town, or Location of Daath: LA PLATA
4c. County of Deeth: CHARLES

Funeral Director

5. Social Sacurity Number: 219-76-4898
6. Sax: 1☐ M 2☒ F
7. Aga (In yrs. last birthday): 33 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Yaar): November 11,1966
9. Birthplaca (Stata or Foraign Country): Maryland

Usual Rasidanca of Decadant

10a. Stata: MD
10b. County: Charles
10c. City, Town or Location: Newburg
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 1154 Mt. Victoria Road
10f. Zip Coda: 20664
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Nevar Married 2☐ Married 3☐ Widowad 4☐ Divorcad
12. Was Decadant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Dacadant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:
14. Raca - Amarican Indian, Black, Whita, atc. Specify: Black

15. Decadant's Education (Spacify only highast grada compladad): Elamantary/Secondary (0-12): 10; Collaga (1-4or 5+):
16a. Decadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired): House Keeper
16b. Kind of Business/Industry: Hotel

17. Fathar's Nama (First, Middla, Last): Joseph Edward Wheeler
18. Mothar's Nama (First, Middla, Maiden Sumama): Mary Adell Cole

19a. Informant's Name/Ralationship (Type, Print): Mary Wheeler/Sister
19b. Mailing Address (Straat and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda): 1 Hickory Lane Apt. 509 La Plata,MD 20646

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramovel from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Placa of Disposition (Nama of cematary, cramatory or other place): Shiloh Church Cem. Dete: 12/10/99
20c. Location - City or Town, Stata: Newburg,MD

21. Signatura of Funaral Service Licensee: C Echols M00174
22. Nama and Addrass of Facility: AREHART-ECHOLS FUNERAL HOME,P.A. P.O. BOX 567 LA PLATA,MD 20646

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complications that causad tha daath. Do not antar tha mода of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only ona cause on aach lina.

Approximata Intarval Batwaen Onsat and Death

Immediate Ceuse (Final disaasa or condition rasulting in daath)
a. CONGESTIVE HEART FAILURE

Dua to (or as a consaquanca of):
b. END STAGE CARDIMYOPATHY

Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Ceusa (Diseasa or injury that initiated avants rasulting in daath) Last
Dua to (or as a consequence of):
c.

Dua to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa givan in Part I.

23b. Did tobecco uae contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Were autopsy findings available prior to complation of cause of daath? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No
26. Placa of Daath (Check only ona): Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined
28a. Data of Injury (Month, Day Yaar)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurrad
28a. Placa of Injury - At home, farm, straat, factory, offica building, atc. (Specify)
28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☒ **Cartifying Physician**: To tha best of my knowladga, deeth occurrad at tha tima, data and placa, and dua to tha causa(s) and manner as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or investigation, in my opinion, daath occurrad at tha tima, data and placa, and due to tha cause(s) and mannar statad.

29b. Signatura and title of certifier: Krishan M. Mathur
29c. Licansa number: D28352
29d. Data signad (Month, Day, Yaar): DECEMBER 6, 1999

30. Nama and addrass of parson who compiatad causa of daath (Item 23a) (Type, Print): KRISHAN MATHUR, MD., P.O. BOX 1703, LA PLATA, MD 20646

State Registrar

31. Data filad (Month, Day, Yaar): DEC 06 1999
32. Registrar's Signatura: G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39802

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert John Walstrum
2. Date of Death: Month Nov. Day 26 Year 1999
3. Time of Death: 8:00pm
4a. Facility Name (If not institution, give street and number): Sunbridge Care
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 221-07-8053
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10/05/1917
9. Birthplace (State or Foreign Country): Maryland

Usuet Residenca of Decedent

10a. Stete: MD
10b. County: Cecil
10c. City, Town or Location: Rising Sun
10d. inside City Limits: 1 [ ] Yes 2 [ ] No
10e. Street end Number: 303 Sunrise Circle
10f. Zip Code: 21911
10g. Citizen of Whet Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, apecify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Reca - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 6th; College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Auto Mechanic
16b. Kind of Business/Industry: Gas Station

17. Father's Name (First, Middle, Lest): John R. Walstrum
18. Mother's Name (First, Middle, Maiden Surname): Naomi C. Mitchell

19a. Informent's Neme/Reletionship (Type, Print): Mabel Walstrum- Wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1 Van Buren Circle, Newark, DE 19702

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): R.A. Ferris & Co. Inc.
Date: 11/30/99
20c. Location - City or Town, Stata: West Chester, PA

21. Signature of Funeral Servica Licansee: Duane M. Smith
22. Name end Address of Facility: Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ahock, or heart failure. List only one cause on eech line.

		Approximete Intervel Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Acute Respiratory distress	24hrs
Due to (or as a consequence of): b.	Aspiration Bronchopneumonia	24hrs
Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Old Cerebrovascular Accident with Aphasia — Hypokyrosidesis — Chr Urinary tract Infection

23b. Did tobacco use contributs to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were eutopsy findings evelleble prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No
26. Place of Deeth (Check only one): Hospital: 1 [ ] inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated. 2 [ ] **Medical Examinar**: On the besis of exemination end/or Investigetion, in my opinion, deeth occurred et the time, dete and placa, end due to the cause(s) end menner steted.

29b. Signature end title of certifier: Gerard L. Kalter MD
29c. License number: D22307
29d. Dete signed (Month, Day, Year): 11/28/99

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): 123 Singerly Ave, ELKTON MD 21921

State Registrar

31. Dete filed (Month, Day, Yeer): NOV 30 1999
32. Registrer's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39803

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy Wynkoop
2. Date of Death (Month, Day, Year): November 29 1999
3. Time of Death: 3:00 AM
4a. Facility Name (If not institution, give street and number): 507 Edenton Retirement Center
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 219-14-9718
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 17 1925
9. Birthplace (State or Foreign Country): Trego MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 507 Edenton Retirement Center
10f. Zip Code: 21701
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Telephone Operaator
16b. Kind of Business/Industry: Phone Company

17. Father's Name (First, Middle, Last): Oscar Charles Boyer
18. Mother's Name (First, Middle, Maiden Surname): Maude Webber

19a. Informant's Name/Reletionship (Type, Print): David R. Carey, Friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5938 Quinn Orchard Rd., Frederick, MD 21704

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Locust Valley Bible Church Cemetery
Date: 12/2/99
20c. Location - City or Town, State: Middletown, MD

21. Signature of Funeral Service Licensee: Barbara A. Williams, Owner
22. Name end Address of Facility: John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 21716

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part 1. Enter the disease, or comptications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart faiture. List only one cause on eech tine.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. Severe Chronic Obstructive Lung Disease 6yrs.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last

b. Due fo (or es e consequence of):

c. Due fo (or es a consequence of):

d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying ceuse given in Part I.

R Lung Cancer 7/95, Osteoporosis with compression spine fracture

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Deeth (Check only one): Hospital: 1☐ tnpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Phyalcian:** To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the besis of examination and/or Investigation, In my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jm L. Harrison MD
29c. License number: D21944
29d. Date signed (Month, Day, Year): 12/1/99

30. Neme and address of person who completed ceuse of death (Item 23e) (Type, Print): James S. Grisson MD 300 W. 9th St Frederick, Md 21701

State Registrar

31. Date filed (Month, Day, Year): DEC 03 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours efter death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39804

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Erma Grace Wise
2. Data of Deeth (Month, Dey, Yaer): December 2,1999
3. Tima of Daath: 2:25pm
4a. Facility Nama (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 170-18-2465
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Dey, Yaar): Oct, 22,1920
9. Birthplaca (State or Foreign Country): Pennsylvania

Usual Residance of Decedent

10a. Stata: Maryland
10b. County: Frederick
10c. City, Town or Location: Thurmont
10d. Inside City Limits: 1☒ Yas 2☐ No
10a. Street and Number: 206 Westview Drive
10f. Zip Code: 21788
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Give Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Raca - Amarican Indian, Black, Whita, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): Manager
16b. Kind of Business/Industry: Food Service
17. Fathar's Nama (First, Middle, Last): Frederick Adams
18. Mothar's Nama (First, Middle, Maiden Surneme): Catherine Benchoff
19a. Informant's Name/Relationship (Type, Print): Diana J. Wetklow / daughter
19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 206 Westview Dr./ Thurmont, Maryland 21788
20a. Mathod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from Stata 4☐ Donetion 5☐ Othar (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): Hagerstown Crematory
Data: 12-3-99
20c. Location - City or Town, Stata: Hagerstown, Maryland
21. Signatura of Funaral Sarvice Licensee: Raymond Peterson
22. Nama and Address of Facility: Stauffer Funeral Home, 104 E. Main St./ Thurmont, Maryland 21788

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complications that caused the death. Do not enter the moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only ona cause on eech line.

Approximata Intarval Batween Onset and Deth

Immediata Causa (Final diseasa or condition resulting in deeth)
a. PULMONARY EMBOLISM — 3 Days
Dua to (or as a consequence of):
b. Pneumonia — 3 Days

Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last
Due to (or as a consequence of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.: Coronary Heart Disease

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wera autopsy findings availeble prior to completion of causa of death? 1☐ Yas 2☐ No

25. Wes casa rafarred to medical examinar? 1☐ Yas 2☒ No

26. Piece of Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☐ Residence 6☐ Othar (Specify)

27. Mennar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledge, daath occurred at tha tima, data and place, and dua to tha ceuse(s) and menner as stated. 2☐ **Medical Examiner:** On tha basis of examinetion and/or invastigation, in my opinion, daath occurred at tha time, date and piece, and due to the ceuse(s) and manner stated.

29b. Signatura and title of certifier:
29c. Licensa number: D43091
29d. Data signed (Month, Day, Year): 12-3-99

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print): SAEED ZAIDI 801 TOLL HOUSE Ave, Frederick, MD

State Registrar

31. Data filed (Month, Day, Year): DEC 06 1999
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with tha Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39805

Amended item#2per doctor 12/13/1999 **Certificate of Death** FCHD,KS Reg. No.

Physician /Medical Examiner

1. Decedant's Nama (First, Middle, Last): Emogene Wenner

2. Data of Death Month 11 Day 30 Year 99: Dec. 1, 1999

3. Tima of Death: 12:30 A.M.

4a. Facility Nama (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 219-66-2860

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Yaar: Months / Days | If Undar 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): May 10 1910

9. Birthplaca (State or Foraign Country): Brunswick, MD

Usual Rasidance of Decedant

10a. Stata: MD

10b. County: Frederick

10c. City, Town or Location: 1530A Souder Road, Knoxville

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 1530A Souder Road

10f. Zip Coda: 21758

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Navar Marriad 2☐ Married 3☒ Widowed 4☐ Divorcad

12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Give Yaar or Dates:

13. Was Decedant of Hispanic Origin? (Spacify Yes or No- If Yas, specity Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - Amaricen Indian, Black, White, etc. Specify: White

15. Decedant's Educetion (Specify only highast grada complatad): Elamentary/Secondary (0-12): 12 | Collega (1-4or 5+):

16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratirad): Farmer

16b. Kind of Businass/Industry: Sprindale Farm

17. Fathar's Nama (First, Middla, Last): John Nevin Souder, Sr.

18. Mothar's Nama (First, Middla, Maidan Sumama): Fannie Rhodes Castle

19a. Informant's Neme/Ralationship (Type, Print): Kay S. Cooper, Niece

19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code): 3637 Petersville Road, Knoxville, MD 21758

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cematary, cramatory or othar place): Reformed Cemetery | Date: 12/4/99

20c. Location - City or Town, State: Jefferson, MD

21. Signature of Funeral Service Licensee: Barbara A. Williams Barbara A. Williams, Owner

22. Nama and Addrass of Facility: John T. Williams Funeral Home, 100 Petersville Road, Brunswick, MD 21716

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not anter the mode of dying, such es cerdiac or raspiratory arrast, shock, or haart failura. List only one causa on aach lina.

Approximata Intarval Batwaen Onsat and Death

Immediate Cause (Final disaasa or condition rasulting in death)
a. Acute myocardial infarction — minutes

Dua to (or as a consequance of):
b. Coronary artery disease — years

Sequantially list conditions, if any, laading to immadiata ceuse. Enter Undarlying Cause (Disaasa or Injury that initiated avants rasulting in death) Last
Dua to (or as a consaquance of):
c.

Dua to (or as a consaquance of):
d.

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying ceusa givan in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☒ No

24b. Wara autopsy findings availabla prior to completion of ceusa of death? 1☐ Yas 2☒ No

25. Was casa rafarrad to medicel axaminar? 1☐ Yas 2☒ No

26. Placa of Daath (Chack only ona) — Hospital: 1☐ Inpatiant 2☒ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Manner of Daath: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be datarmined

28a. Date of Injury (Month, Day Yaar)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascriba how injury occurrad

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Straat and Number or Rural Route Numbar, City or Town, Stata)

29a. Certifiar (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to tha causa(s) and mannar statad.

29b. Signatura and tita of certifiar: Kathleen W Stern MD

29c. Licanse number: D32073

29d. Date signed (Month, Day, Yaar): 12/3/99

30. Name and addrass of parson who complatad causa of daath (Item 23a) (Type, Print): Kathleen W Stern MD, 610 Ninth Ave, Brunswick, Md. 21716

State Registrar

31. Data filed (Month, Day, Yaar): DEC 06 1999

32. Registrar's Signatura: G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39806

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Virginia Irene Way

2. Date of Death (Month, Day, Year): November 26, 1999

3. Time of Death: 3:05 PM

4a. Facility Name (If not institution, give street and number): Wilson Health Care Center

4b. City, Town, or Location of Death: Gaithersburg

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 377-30-4911

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 2, 1916

9. Birthplace (State or Foreign Country): MI

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6102 Kirby Road

10f. Zip Code: 20817

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Thomas Morgan

18. Mother's Name (First, Middle, Maiden Surname): Martha Fox

19a. Informant's Name/Relationship (Type, Print): Richard Way/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6102 Kirby Road, Bethesda, Maryland 20817

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Michael's Cemetery

Date: Dec. 3, 1999

20c. Location - City or Town, State: Coopersville, Michigan

21. Signature of Funeral Service Licensee: Michael D. Wilbrand

22. Name and Address of Facility: DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Septicemia — 1 week

Due to (or as a consequence of):

b. Pyoderma gangrenosum — 6 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Crohn's colitis

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Anemia of chronic disease
Monoclonal gammopathy
lung mass

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: H. Robert Birschbach, M.D.

29c. License number: 04115

29d. Date signed (Month, Day, Year): November 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): H. Robert Birschbach, M.D., 6320 Democracy Blvd., Bethesda, MD 20817

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999

32. Registrar's Signature: Renee B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39807

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Elwood Wease
2. Date of Death (Month, Day, Year): November 28, 1999
3. Time of Death: 3:30 pm
4a. Facility Name (If not institution, give street and number): 5016 Baltic Avenue
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 214-30-2116
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 65 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 2, 1934
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 5016 Baltic Avenue
10f. Zip Code: 20853
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: Korea
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No Specify:
14. Race - American indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Yard Foreman
16b. Kind of Business/Industry: Devlin Lumber

17. Father's Name (First, Middle, Last): Calvy R. Wease
18. Mother's Name (First, Middle, Meiden Surname): Primrose V. Joseph

19a. Informent's Neme/Reletionship (Type, Print): Robert L. Wease (son)
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 5016 Baltic Avenue Rockville,Maryland 20853

20a. Method of Disposition: 1☒Buriel 2☐Cremetion 3☐Removel from Stete 4☐Donetion 5☐Other (Specify)
20b. Plece of Disposition (Name of cemetery, cremetory or other piece): Gate of Heaven Cemetery
Dete: 12/1/99
20c. Location - City or Town, Stete: Silver Spring,Maryland

21. Signature of Funerel Service Licensee: Steven Strand
22. Name end Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Silver Spring,MD 20901

Physician /Medical Examiner

23e. Pert1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart feilure. List only one cause on eech line.

		Approximate Interval Between Onset end Death
Immediate Ceuse (Finel disease or condition resulting in deeth) e.	respiratory feulure	2 weeks
Due to (or as a consequence of): b.	metastatic lung cancer	2 months
Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last — Due to (or es a consequence of): c.		
Due to (or es a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Wes en autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred to medical examiner? 1☐Yes 2☒No

26. Place of Deeth (Check only one): Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Menner of Death: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury el Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Cmaung, MD
29c. License number: D 45274
29d. Date signed (Month, Day, Year): 11/30/99.

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Cho Maung, M.D. 10810 Connecticut Avenue Kensington,Maryland 20895

State Registrar

31. Date filed (Month, Dey, Yeer): DEC 01 1999
32. Registrer's Signeture: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39808

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EVERETT RUSSELL WELLS SR.
2. Date of Death: Month NOV. Day 26, Year 1999
3. Time of Death: 3:10 AM
4a. Facility Name (If not institution, give street and number): ST. THOMAS MORE NURSING HOME
4b. City, Town, or Location of Death: HYATTSVILLE
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 227-05-6909
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 21, 1917
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: D.C.
10b. County: NONE
10c. City, Town or Location: WASHINGTON
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 527 MADISON ST. N.E.
10f. Zip Code: 20011
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): D.C. METROPOLITAN POLICEMAN
16b. Kind of Business/Industry: LAW ENFORCEMENT

17. Father's Name (First, Middle, Last): JOHN WELLS
18. Mother's Name (First, Middle, Maiden Surname): EVA M. BOWLER

19a. Informant's Name/Relationship (Type, Print): PAMELA A. JENIFER/DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ITEM #10

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CHAMBERS CREMATORY | Date: 12/2/99
20c. Location - City or Town, State: RIVERDALE, MD.

21. Signature of Funeral Service Licensee: W. W. Chambers MO0091
22. Name and Address of Facility: CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D42936
29d. Date signed (Month, Day, Year): 11-29-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 1160 Varnum St NE Suite 213 WDC 20017 DR. ELWIN BUSTOS, M.D.

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39809

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert A. Williams
2. Data of Death — Month: November Day: 30 Year: 1999
3. Time of Death: 10:00pm
4a. Facility Name (If not institution, giva street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 187-24-0102
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 68 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Yaar): Oct 8, 1931
9. Birthplace (Stata or Foreign Country): Maryland

Usual Residence of Decedant

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 12612 Littleton St
10f. Zip Code: 20906
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Marriad 2☒Married 3☐Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yaar or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elemantery/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Vice President
16b. Kind of Business/Industry: Moving Company

17. Fathar's Name (First, Middle, Last): Eugene Williams
18. Mother's Name (First, Middle, Maiden Surnama): LaVerne B Barth

19a. Informant's Name/Relationship (Type, Print): Jane M. Williams / Wife
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 12612 Littleton St., Silver Spring, MD 20906

20a. Mathod of Disposition: 1☒Burial 2☐Cramation 3☐Removal from Stete 4☐Donation 5☐Othar (Specify)
20b. Place of Disposition (Nama of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: 12/3/99
20c. Location - City or Town, State: Silver Spring, MD

21. Signatura of Funaral Service Licensee: William J Byrd
22. Nama and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd, W, Silver Spring, MD 20901

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused tha deeth. Do not enter the mode of dying, such es cardiac or raspiratory arrest, shock, or heart failura. List only ona cause on eech line.

Approximete Interval Between Onset end Death

Immediata Causa (Final disaasa or condition rasulting in deeth)
a. Aspiration Pneumonia — 3days

Dua to (or as a consequence of):

Sequentially list conditions, if any, laading to immedieta causa. Enter Underlying Cause (Diseese or injury that initieted avants resulting in death) Last
b.
Due to (or as a consequence of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditiona** contributing to death but not rasulting in the underlying cause given in Part I.: Parkinsons Disease

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yas 2☑No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Wes casa rafarred to medical examinar? 1☐Yas 2☑No

26. Place of Deeth (Check only ona)
Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicida 4☐Homicida 5☐Pending investigation 6☐Could not be determined

28a. Data of Injury (Month, Day Yaar)
28b. Tima of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Cartifiar (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐**Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, death occurred at the tima, date and place, and dua to tha cause(s) and menner stated.

29b. Signatura and titla of certifier: Arbrathan MD
29c. License number: D0053615
29d. Data signed (Month, Day, Yaar): December, 1st, 1999

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print): Aruna S Nathan, 121 Congressional Lane, Suite 409, Rockville MD

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Data filed (Month, Day, Yaar): DEC 02 1999
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Williams, Robert DoB: 10/08/31 Death: 11/30/99 @ 10 Pm

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39810

Certificate of Death

Reg. No.

Ethel O. Wright

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ETHEL OPHELIA WRIGHT

2. Data of Death Month Day Yaar: December 6 1999

3. Time of Death: 10:25pm

4a. Facility Name *(If not institution, giva street and number)*: Civista Medical Center

4b. City, Town, or Location of Death: LaPlata

4c. County of Death: Charles

Funeral Director

5. Social Security Number: 214-30-1053

6. Sex: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 12 1908

9. Birthplace *(State or Foraign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Charles

10c. City, Town or Location: La Plata

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: One Magnolia Drive La Plata Center Genesis Elder Care

10f. Zip Code: 20646

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grade completed)*: Elementary/Secondary (0-12): 5 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Nama *(First, Middla, Last)*: Joseph A. Wenk

18. Mother's Nama *(First, Middla, Maiden Surnema)*: Mary L. Nebitt Wenk

19a. Informant's Name/Ralationship *(Type, Print)*: Doris M, Coombs

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: PO Box 146 Pomfret, MD 20675

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Nanjemoy Baptist Ch. Cem. Data: 12-10-99

20c. Location - City or Town, Stata: Nanjemoy, MD

21. Signature of Fatheral Service Licensee: John A Flenn M00193

22. Name and Address of Facility: Eberwein Funeral Services 4433 White Pls La White Pls., MD 20695

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease or complications that caused the death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only ona cause on each line.

Approximate Intarval Between Onset and Death

Immediata Causa (Finet disease or condition resulting in death)

a. Pneumonia — x one day

Due to (or as a consequence of):

b. Advanced Arteriosclerosis — x years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Coronary Artery Disease — x years

Due to (or as a consequence of):

d. Cerebral Vascular Disease — x years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

Chronic Lymphedema

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings availabla prior to complation of causa of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yas 2☒ No

26. Place of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☐ Residence 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To tha best of my knowledge, death occurred at the time, date and placa, and dua to tha causa(s) and mannar as statad. 2☐ **Medical Examiner**: On the basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and placa, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D - 20629

29d. Data signed *(Month, Day, Year)*: 12/7/99

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): George H. Wathen, MD — 11345 Pembrooke Square, Suite 103 Waldorf, Maryland 20603

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 09 1999

32. Registrar's Signatura: Jenna G. Sparks

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39811

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Naomi Bernice Young

2. Date of Death Month: DECEMBER Day: 02 Year: 1999

3. Time of Death: 2:26 AM

4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL OF BALTIMORE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 284-24-6886

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 71 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr. 22, 1928

9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Darlington

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 4104 Conowingo Road

10f. Zip Code: 21034

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bartender

16b. Kind of Business/Industry: NCO Club

17. Father's Name (First, Middle, Last): Benjamin Lewis Rodman

18. Mother's Name (First, Middle, Maiden Surname): Clarice Bell Evans

19a. Informant's Name/Relationship (Type, Print): Mary A. Young (Daughter in law)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 266 Grove St., Delta, PA 17314

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Harford Memorial Gardens

Date: 12/6/99

20c. Location - City or Town, State: Aberdeen, Maryland

21. Signature of Funeral Service Licensee: Kenneth B. Cargo

22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

PATIENT KNOWN AS NAOMI YOUNG

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION — 3 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: T. A. Cuvad MD

29c. License number: RES-000

29d. Date signed (Month, Day, Year): DECEMBER 02 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THOMAS ANTHONY CUVAD SINAI HOSPITAL OF BALTIMORE 2401 WEST BELVADERE AVENUE BALTIMORE, MARYLAND 21215

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): DEC 06 1999

32. Registrar's Signature: Jeanine B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39812

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WALTER RUSSELL ZIMMERMAN
2. Date of Death (Month, Day, Year): NOV. 26, 1999
3. Time of Death: 7:40 AM
4a. Facility Name (If not institution, give street and number): NATIONAL LUTHERAN HOME
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 160-16-4138
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR.12,1917
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 9513 VEIRS DRIVE #2
10f. Zip Code: 20850
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify: XX
14. Race - American Indien, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MINISTER
18b. Kind of Business/Industry: CLERGY

17. Father's Name (First, Middle, Last): WALTER S. ZIMMERMAN
18. Mother's Name (First, Middle, Maiden Surname): DAYSIE JANE RUSSELL

19a. Informent's Name/Relationship (Type, Print): CATHERINE S.ZIMMERMAN-WIFE
19b. Malling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 9513- VEIRS DRIVE, ROCKVILLE,MD.20850

20e. Method of Disposition: 1 [ ] Buriel 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) / Date: METROPOLITAN CREMATORY-11/27-ALEXANDRIA,VA.
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: D. M. Hysong
22. Neme end Address of Facility: HYSONG CO.,INC. FUNERAL HOME 1300- N STREET, NW, WASH.,DC

Physician /Medical Examiner

23a. Part1. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in deeth)
a. Pneumonia — days

Due to (or as a consequence of):
b. End Stage Chronic Obstructive Pulmonary Disease — years

Sequentielly list conditions, if any, leading to immedіete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Piece of Deeth (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Menner of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined
28a. Date of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or Investigetion, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D33138
29d. Date signed (Month, Day, Year): November 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Daniel A Taller, MD 12852 Middlebrook Rd, Germantown, MD

State Registrar

31. Dete filed (Month, Day, Year): DEC 01 1999
32. Registrar's Signature: B. Smith

Baltimore, Maryland 21215-0020

Permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(4)

DHMH 16 Rev 6/95

DEC 01 1998

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39813

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leonard G. Zigmund

2. Date of Death: Month November Day 27, Year 1999

3. Time of Death: 7:25P.

4a. Facility Name (If not institution, give street and number): Magnolia Center Genesis Elder Care

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 187-16-2171

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 27,1922

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Greenbelt

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 22 Ridge Road, #132

10f. Zip Code: 20770

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1944-1946

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Brick Mason

16b. Kind of Business/Industry: Oak-Port

17. Father's Name (First, Middle, Last): Frank Zigmund

18. Mother's Name (First, Middle, Maiden Surname): Mary Navitsky

19a. Informant's Name/Relationship (Type, Print): Alice Perry Zigmund (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as #10

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory | Date: 11/28/1999

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Donald V. Borgwardt

22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: George C. Hagar, Jr. MD

29c. License number: 039550

29d. Date signed (Month, Day, Year): 11-25-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): George C. Hagar, Jr. MD 4850 Forbes Blvd Lanham, Md. 20706

State Registrar

31. Date filed (Month, Day, Year): NOV 30 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39814

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kathleen M. Althoff
2. Date of Death Month Day Year: December 14, 1999
3. Time of Death: 7:30 PM
4a. Facility Name (If not institution, give street and number): Manor Care- Roland Park
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-34-9857
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4-28-1908
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4669 Falls Road
10f. Zip Code: 21209
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Legal

17. Father's Name (First, Middle, Last): Sylvester Stark
18. Mother's Name (First, Middle, Maiden Surname): Annie Fitzpatrick

19a. Informant's Name/Reletionship (Type, Print): Mr. James M. Althoff (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15 Seven Springs Court, Phoenix, Maryland 21131

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): New Cathedral Cemetery
Date: 12-18-99
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Wallace S Brooks, Jr
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Chronic Hypoxemia
Due to (or as a consequence of):
b. Respiratory Failure
Due to (or as a consequence of):
c. Chronic Obstructive Lung Disease
Due to (or as a consequence of):
d. Congestive Heart Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Michael A Randolph MD
29c. License number: D34680
29d. Date signed (Month, Day, Year): 12-16-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 3333 N. CALVERT ST #655 BALTIMORE MD 21218

State Registrar

31. Date filed (Month, Day, Year): DEC 20 1999
32. Registrar's Signature: ▶ B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39815

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Calvin Avent

2. Data of Death: Month December Day 15 Year 1999

3. Time of Death: 8:45 AM

4a. Facility Name (If not institution, give street and number): THE Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore, City

4c. County of Death:

Funeral Director

5. Social Security Number: 212-48-2861

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 52 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): 06-12-47

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Insida City Limits: 1 [X] Yas 2 [ ] No

10e. Street and Number: 1503 N. Broadway

10f. Zip Code: 21213

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Nevar Married 2 [X] Merried 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yas, Giva Yaer or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - American Indien, Black, Whita, atc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th Grade

College (1-4or 5+): B.A. Degree

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Full-time

16b. Kind of Businass/Industry: City of Baltimore Lemell Middle Sch.

17. Fathar's Nama (First, Middle, Last): William Avent

18. Mother's Nama (First, Middle, Maiden Sumame): Blanche Holland

19a. Informant's Name/Ralationship (Type, Print): Geraldyn Avent

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1503 N. Broadway Baltimore, MD. 21213

20a. Mathod of Disposition: [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Ptace of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery

Data: 12-21-99

20c. Location - City or Town, Stata: Woodlawn, MD.

21. Signature of Funeral Service Licensee: Valorie M. Davis

22. Nama and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter tha disaase, or complications that caused tha daath. Do not antar the moda of dying, such as cardiac or raspiratory arrest, shock, or haart tailure. List only ona cause on aach lina.

Approximata Intarval Between Onsat and Daath

Immedieta Ceuse (Finel disaasa or condition rasulting in death)

a. Cerebellar Hemorrhage — 2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

b.

Dua to (or as a consequence of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contributa to the causa of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings available prior to complation of cause of death? 1 [ ] Yas 2 [ ] No

25. Was casa referred to medical examinar? 1 [ ] Yas 2 [X] No

26. Placa of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding invastigation 6 [ ] Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To tha best of my knowledge, death occurred at the tima, date and place, and dua to the cause(s) and mannar as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, deeth occurred et the tima, date and place, and due to tha cause(s) and mannar stated.

29b. Signature and title of certifier: Michael A. Williams, MD

29c. License number: 040041

29d. Data signed (Month, Day, Year): December 15, 1999

30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print): 600 N. Wolfe St, Meyer 8-140 Baltimore, MD 21287

State Registrar

31. Data filed (Month, Day, Year): DEC 20 1999

32. Registrar's Signatura: Diane P Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by tha funeral director, page 2 should be detached for use as the burial-transit

99-7578-005

DDG AMEND ITEM:#28B PER MEO G781 3-17-2000 WR.

THOMAS E. BROWERS AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G780 2-14-2000 WR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39816

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): THOMAS EDWIN BROWER

2. Date of Death (Month, Day, Year): DECEMBER 14, 1999

3. Time of Death: 1805 PM

4a. Facility Name (If not institution, give street and number): MANOR HEALTH CARE ROSSVILLE

4b. City, Town, or Location of Death: ROSEDALE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 155-09-3331

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sep. 29, 1913

9. Birthplace (State or Foreign Country): N.J.

Usual Residence of Decedant

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 12 Turnmill Ct.

10f. Zip Code: 21236

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No If Yas, Giva Yaar or Datas: WW-II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elamantary/Secondary (0-12): 8

Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Master Carpenter

16b. Kind of Business/Industry: Construction

17. Fathar's Nama (First, Middle, Last): George Brower

18. Mother's Nama (First, Middle, Maiden Surname): Annie Mitchell

19a. Informant's Name/Relationship (Type, Print): Mr. Thomas Brower/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12 Turnmill Ct. Baltimore, Md. 21236

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Place of Disposition (Name of cematery, crematory or other place): Holly Hill Cemetery

Data: 12/20/99

20c. Location - City or Town, State: Middle River, MD.

21. Signatura of Funeral Service Licansee:

22. Nama and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complicetions thet caused tha daath. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or haart feilure. List only ona cause on each line.

Approximata Intarval Between Onset and Death

Immediata Cause (Final disaasa or condition resulting in daath): a. PNEUMONIA AND HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE COMPLICATING REMOTE HEAD AND CHEST INJURIES

Dua to (or as e consequence of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disease or Injury that initiated events resulting in death) Last: b.

Due to (or es a consequence of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Ware autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [ ] No

25. Was casa rafarred to medical examiner? [X] Yas 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA Other: [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Mannar of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending Invastigetion 6 [ ] Could not be determined

28a. Data of Injury (Month, Day, Year): 11-5-97

28b. Time of Injury: ~~UNKNOWN~~ 3:30 P ~~M~~

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: DRIVER OF CAR IN AN IMPACT WITH FIXED OBJECT

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify): ROAD

28f. Location (Street and Number or Rural Route Number, City or Town, State): PHILADELPHIA ROAD WHITE MARSH MD

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2 [X] **Medical Examiner**: On tha basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifia:

29c. License number: O.C.M.E.

29d. Data signed (Month, Day, Year): DECEMBER 17, 1999

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): [illegible] A. KOGER 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year): DEC 20 1999

32. Registrar's Signature: Bonnie B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39817

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Nellie L. Bender

2. Date of Death — Month: DECEMBER Day: 17th Year: 1999

3. Time of Death: 6:23 pm

4a. Facility Name *(If not institution, give street and number)*: Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-84-7723

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 07/03/1914

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2810 Echodale Avenue

10f. Zip Code: 21214

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher

16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: Harry Leonard

18. Mother's Name *(First, Middle, Maiden Surname)*: Isabelle Morganroth

19a. Informant's Name/Relationship *(Type, Print)*: Mr. John Bender/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 17204 Wesley Chapel Road, Monkton, Maryland 21111

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Joseph Fullerton

Date: 12/21/99

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Christina L.David — Christina L. David

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, Maryland 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS	3 days
Due to (or as a consequence of):	RUPTURED DIVERTICULUM OF ABDOMEN	3 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):	c.	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, strast, factory, office building, etc. *(Specify)*

28f. Location *(Street and Numbar or Rural Routa Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and dua to the cause(s) end mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: GULATI, MD.

29c. License number: AT 2438946

29d. Date signed *(Month, Day, Year)*: DECEMBER 17th 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MANGLA GULATI, UNION MEMORIAL HOSPITAL, EAST UNIVERSITY PARKWAY, BALTIMORE, MD

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 20 1999

32. Registrar's Signature: Bernice G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend 5 per fh 12/28/99 yag

Certificate of Death

Reg. No. 99 39818

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RICHARD B. BEASLEY

2. Date of Death Month: 12 Day: 16 Year: 99

3. Time of Death: 8 AM

4a Facility Name *(If not institution, give street end number)*: 1615 E. Biddle ST

4b. City, Town, or Location of Death: BALTO.

4c. County of Death: N.A

Funeral Director

5. Social Security Number: 214 38 4879

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 59 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 12-7-40

9. Birthplace *(State or Foreign Country)*: Md.

Usual Residence of Decedent

10a. State: Md | 10b. County: N.A. | 10c. City, Town or Location: Balto. | 10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1615 E. Biddle St. | 10f. Zip Code: 21213 | 10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Vehicle Operator

16b. Kind of Business/Industry: Soc. Security Adm

17. Father's Name *(First, Middle, Last)*: Wm. Beasley

18. Mother's Name *(First, Middle, Maiden Surname)*: Mamie Byrd

19a. Informant's Name/Relationship *(Type, Print)*: VIVIAN BEASELEY wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1615 E. Biddle St BALTO. Md 2123

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: King Mem. Pk | Date: 12/20/99

20c. Location - City or Town, State: Balto. County

21. Signature of Funeral Service Licensee: Joseph B. Locke, Jr.

22. Name and Address of Facility: Joseph G. Locke Jr F/H 1304 N. Central Ave

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MANTLE CELL LYMPHOMA (METASTATIC)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

TYPE 2 DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MEDICAL DOCTOR ATTENDING PHYSICIAN

29c. License number: D0052803

29d. Date signed *(Month, Day, Year)*: 12/17/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): OLUWATOYIN OLATINWO, 1900 E. EAGER ST, BALTIMORE, MD 21202

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 20 1999

32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39 1209

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gertrude Bowers

2. Date of Death — Month: December Day: 15 Year: 1999

3. Time of Death: 1209

4a. Facility Name *(If not institution, give street and number)*: Bon Secours Hosp

4b. City, Town, or Location of Death: Balto. City

4c. County of Death:

Funeral Director

5. Social Security Number: 217-22-2677

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: 4-17-1922

9. Birthplace *(State or Foreign Country)*: Md

Usual Residence of Decedent

10a. State: Md

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 633 N. Fulton Ave

10f. Zip Code: 21217

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12th grade

College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: NA

16b. Kind of Business/Industry: NA

17. Father's Name *(First, Middle, Last)*: William Harry Bowers

18. Mother's Name *(First, Middle, Maiden Surname)*: Hattie V. Booze

19a. Informant's Name/Relationship *(Type, Print)*: Charles Bowers - Brother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 521 Radnor Avenue Balto, Md 21212

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory, or other place)*: Arbutus Mem Part 2

Date: 12-23-99

20c. Location - City or Town, State: Arbutus, Md

21. Signature of Funeral Service Licensee: John B. Johnson

22. Name and Address of Facility: March F.H. West 4300 Wabash Avenue Balto, Md

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HCVD

Due to (or as a consequence of):

b. Diabetes mellitus

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Diabetic neuropathy

Due to (or as a consequence of):

d. Diabetic ulcer both legs

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D05629

29d. Date signed *(Month, Day, Year)*: 12-17-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TURGOT JEUDY, M.D 5749 N. FULTON Ave, Balto, Md 21223

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 20 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39820

Amend Item # 20b, 12/22/99, G778, per G&P F.H.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANCES BROOMS
2. Date of Death Month: 12 Day: 17 Year: 1999
3. Time of Death: 1305
4a. Facility Name (If not institution, give street and number): BON SECOURS HOSPITAL
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 212-36-5135
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 60 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEBRUARY 3, 1939
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 1129 N. STRICKER STREET
10f. Zip Code: 21217
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☑ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12; Collega (1-4or 5+): 8
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER
16b. Kind of Business/Industry: School

17. Father's Neme (First, Middle, Last): Robert Dowdy Sr
18. Mother's Name (First, Middle, Maiden Surneme): Fannie Mae Dowdy

19a. Informent's Neme/Reletionship (Type, Print): Michelle A. Brom grand daughter
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 1129 N. Stricker St. Baltimore, MD 21217

20a. Method of Disposition: 1☑ Buriel 2☐ Cremation 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Pleca of Disposition (Neme of cemetery, cremetory or other place): Arlington Memorial Park
Dete: 12-23-99
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee: Brandon M. Wylie
22. Name and Address of Facility: Albert P. Wylie Funeral Home, PA 638 N. Elmor St. Baltimore, MD 21217

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert feilure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disaase or condition resulting in deeth): e. myocardial infarction
Due to (or as a consequence of):
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Lest:
b. Gastric Bleeding
Due to (or es e consequence of):
c. Liver Disease
Due to (or es a consequence of):
d. Chronic lung disease

Pert II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☐ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding Investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred el the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and piece, end due to the cause(s) and menner steted.

29b. Signature end title of certifier: Dr John H. Adkins
29c. License number: D0029968
29d. Date signed (Month, Day, Year): 12-17-1999

30. Neme end address of person who completed cause ot death (Item 23a) (Type, Print): 2000 West Baltimore Street Baltimore, Maryland

State Registrar

31. Dete filed (Month, Dey, Year): DEC 20 1999
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

AH

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39821

AMENDED ITEM #5 PER FH G778 12/20/99 AH

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Robert Brown	December 11 1999	10:45 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Joseph Ritchie Hospice 828 N. Eutaw St	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
~~219-50-6442~~ 29-50-6442	1☒ M 2☐ F	51 Yrs.			Jan 15, 1948	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
1918 Washington Street	21213	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☐ No If Yes, Give Year or Dates: unknown	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
unknown	unknown	meat cutter	restaurant

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
unknown	unknown

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ms. Monaham/Jos Ritchie Hospice	828 N. Eutaw Street Balto, MD 21201

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify)			

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Ronald S. Wade, Director	StateAnatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death)	a. Hepatic and renal failure	6 mos.
	Due to (or as a consequenca of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last	b. Cirrhosis of liver	yeans
	Due to (or as e consequence of):	
	c. Alcoholism	years
	Due to (or es a consequence of):	
	d. Hepatitis B and C	yeans

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
G.I. bleeding

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) hospice

27. Manner of Death	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and placa, and due to the ceuse(s) end menner as stated.
2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] M.D.	D13006	12/12/99

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)
Thomas Powell, 601 W. Read St. Baltimore, Md. 21217

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 20 1999	[signature] G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Robert Brown 12/11/99 10:45

A14

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM #5 PER AB G778 12/20/99 AH

Certificate of Death

Reg. No. 99 39822

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ESSIE MAE BELL

2. Date of Death Month DEC Day 10 Year 1999

3. Time of Death: 9:57 PM

4a. Facility Name *(If not institution, give street and number)*: NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death: BETHESDA

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: ~~402-12-4262~~ 402-124262

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 29, 1918

9. Birthplace *(State or Foreign Country)*: Kentucky

Usual Residence of Decedent

10a. State: Md

10b. County: Montgomery

10c. City, Town or Location: Silver Springs

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10317 Insley Drive

10f. Zip Code: 20902

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: computer operator

16b. Kind of Business/Industry: navy

17. Father's Name *(First, Middle, Last)*: Lige William Depew

18. Mother's Name *(First, Middle, Maiden Surname)*: Susan E. Lyons

19a. Informant's Name/Relationship *(Type, Print)*: Crystal Grimsley/daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10317 Insley St Silver Springs, MD 20902

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. CLOSTRIDIUM DIFFICLE COLITIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: 153491 (MA)

29d. Date signed *(Month, Day, Year)*: 13 DEC 99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. J. FROIO, LT, MC, USN

NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 20 1999

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

md LATE

AH

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39823

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ruth G. Chambers

2. Date of Death Month Day Year: December 17, 1999

3. Time of Death: 12:30 a.m.

4a. Facility Name *(If not institution, give street and number)*: Good Samaritan Nursing Center

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-03-3866

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 7, 1918

9. Birthplace *(State or Foreign Country)*: Baltimore, Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1601 E. Belvedere Ave.

10f. Zip Code: 21239

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 2

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Executive Secretary

16b. Kind of Business/Industry: Metal Finisher

17. Father's Name *(First, Middle, Last)*: Frank P. Goldschmidt

18. Mother's Name *(First, Middle, Maiden Surname)*: Louisa S. Miller

19a. Informant's Name/Relationship *(Type, Print)*: Michael R. Chambers (Son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7102 Park Place Baltimore, Maryland 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Oak Lawn Cemetery

Date: 12/20/99

20c. Location - City or Town, State: Baltimore Maryland

21. Signature of Funeral Service Licensee: Milton J Knight Jr — Milton J. Knight Jr.

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore. Maryland 21214

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximata Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia — 4days

Due to (or as a consequence of):

Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting In tha undarlying causa given in Part I.

Deep Venous Thrombosis

Alzheimer's Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. tnjury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Carl Sperling

29c. License number: D28987

29d. Data signed *(Month, Day, Year)*: 12-17-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CARL SPERLING, M.D. 5601 LOCH RAVEN BLVD BALTO. MD 21239

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 20 1999

32. Registrar's Signature: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other then 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39824

Amended Item#28f perPhyG778 12/20/99 EW

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Roy Chicks

2. Date of Death: Month: October Day: 26, Year: 99

3. Time of Death: 12:50

4a. Facility Name (If not institution, give street and number): 134 First St

4b. City, Town, or Location of Death: Salisbury

4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 214-32-5509

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 86 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb 26, 1912

9. Birthplace (State or Foreign Country): unknown

Usual Residence of Decedent

10a. State: MD

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 134 First Street

10f. Zip Code: 21801

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4or 5+): unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown

16b. Kind of Business/Industry: unknown

17. Father's Name (First, Middle, Last): unknown

18. Mother's Name (First, Middle, Maiden Surname): unknown

19a. Informant's Name/Relationship (Type, Print): unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): unknown

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Esophageal carcinoma	2 mos.
Due to (or as a consequence of):	b. alcohol abuse	unknown
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. tobacco abuse	unknown
Due to (or as a consequence of):	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: none

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year):

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred:

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):

28f. Location (Street and Number or Rural Route Number, City or Town, State): ~~134 First St. Salisbury, MD~~

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gail C.S. Anderson MD

29c. License number: D45190

29d. Date signed (Month, Day, Year): 10/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GAIL C.S. ANDERSON, M.D., Dept. of Radiation Oncology, Peninsula Regional Med. Ctr. 100 E. CARROLL ST., SALISBURY, MD 21801

State Registrar

31. Date filed (Month, Day, Year): DEC 20 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39825

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GUY J CICONE
2. Date of Death: Month DECEMBER Day 17 Year 1999
3. Time of Death: 12:38 P.M.

4a. Facility Name (If not institution, give street and number): Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 218-05-9176
6. Sex: ☒ M ☐ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 20, 1918
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 3810 MacAlpine Road
10f. Zip Code: 21042
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1942-47
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Judge
16b. Kind of Business/Industry: Circuit Court

17. Father's Name (First, Middle, Last): Carl P. Cicone
18. Mother's Name (First, Middle, Maiden Surname): Dora Mancinelli

19a. Informant's Name/Relationship (Type, Print): Marie J. Cicone / spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3810 MacAlpine Rd. Ellicott City, MD. 21042

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Memorial Park | Date: Dec. 21 1999
20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. PNEUMONIA — 72 HOURS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CEREBROVASCULAR DISEASE
ATRIAL ARRHYTHMIAS

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of Certifier: [signature] MD
29c. License number: D29909
29d. Date signed (Month, Day, Year): DECEMBER 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SCOTT MAURER MD 9501 OLD ANNAPOLIS RD ELLICOTT CITY MD 21042

State Registrar

31. Date filed (Month, Day, Year): DEC 20 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39826

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDWARD P. CHACHULSKI
2. Date of Death (Month, Day, Year): DEC. 13, 1999
3. Time of Death: 7:45AM
4a. Facility Name (If not institution, give street and number): EASTPOINT NURSING HOME
4b. City, Town, or Location of Death: DUNDALK
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 120-18-9228
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 8, 1922
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 309 ELRINO STREET
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1947-48
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 4TH | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): WASTEWATER
16b. Kind of Business/Industry: BALTIMORE CITY

17. Father's Name (First, Middle, Last): STANLEY CHACHULSKI
18. Mother's Name (First, Middle, Meiden Sumeme): STELLA RAMAZEWSKI

19a. Informant's Name/Relationship (Type, Print): ELVA CHACHULSKI/WIFE
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 309 ELRINO ST., BALTIMORE MD. 21224

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other place): BALTIMORE WASHINGTON
Date: 12/15/99
20c. Location - City or Town, State: LAUREL, MD.

21. Signature of Funeral Service Licensee: Elizabeth Selenski
22. Name and Address of Facility: CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 21224

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respirafory errest, shock, or heart tailure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disaase or condition resulting in death): a. Dementia
Due to (or as a consequenca of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequenca of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditione** confributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D43725
29d. Date signed (Month, Dey, Year): 12/15/99

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print): TARIQ MAHMOUD 821. N. Eutaw St Suit 308 Baltimore MD 21201

State Registrar

31. Dete filed (Month, Dey, Year): DEC 20 1999
32. Registrar's Signature: Penne D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39827

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARION M. CELLANTE
2. Data of Death: Month DEC. Day 13 Year 1999
3. Time of Death: 1:30PM
4a. Facility Name (If not institution, give street and number): 7257 CONLEY STREET
4b. City, Town, or Location of Death: EASTWOOD
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 219-28-9236
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Yaar: Months / Days | If Undar 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): SEPT.26,1932
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: EASTWOOD
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 7257 CONLEY STREET
10f. Zip Code: 21224
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Race - American Indian, Black, White, atc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SECRETARY
16b. Kind of Businass/Industry: BANKING

17. Father's Nama (First, Middle, Last): RUDOLPH HOPKA
18. Mothar's Nama (First, Middle, Maiden Surname): MARGARET WISE

19a. Informant's Name/Ralationship (Type, Print): JOHN CELLANTE - HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7257 CONLEY STREET BALTIMORE, MARYLAND 21224

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other placa): OAK LAWN CEMETERY
Data: 12/16/99
20c. Location - City or Town, Stata: BALTIMORE, MARYLAND

21. Signature of Funarel Service Licensee: Elizabeth Selenske
22. Nama and Address of Facility: CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVENUE BALTIMORE, MARYLAND 21224

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha death. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or inkart failura. List only ona causa on aach lina. (Approximata Intarval Batwaen Onset and Death)

Immediata Causa (Final diseasa or condition resulting in death)
a. Breast CA, advanced & distant

Sequentially list conditions, if any, leading to immadiata ceuse. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last
Dua to (or as a consequenca of):
b. cardiac arrest & pulmonary failure 9 month
Dua to (or as a consequenca of):
c. Severe mental disturbances due to
Dua to (or as a consequance of):
d. Bipolar disorder

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yas 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No
24b. Wara autopsy findings available prior to completion of causa of death? 1☐ Yas 2☐ No

25. Was casa rafarrad to madical examiner? 1☐ Yas 2☑ No

26. Place of Death (Check only ona)
Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA
Other: 4☐ Nursing Homa 5☑ Rasidence 6☐ Othar (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined
28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To tha best of my knowledga, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signature and title of certifier: MD
29c. License number: D-42630
29d. Data signed (Month, Day, Year): 12-16-99

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print): E. Weinman MD FR. Sq. Hospital 9100 Fra. Square Drive

State Registrar

31. Data filed (Month, Day, Year): DEC 20 1999
32. Registrar's Signatura: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 99 39828

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas Horace Crawford
2. Date of Death Month Day Yeer: Dec. 09, 99
3. Time of Death: 7:13pm
4a Facility Name (If not institution, give street and number): 2032 E. Lafayette Street Apt."B"
4b. City, Town, or Location of Death: Baltimore
4c. County of Deeth: NA

Funeral Director

5. Social Security Number: 577-54-6309
6. Sex: 1☐M 2☐F XX
7. Age (In yrs. last birthday): 58 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Dey, Year): 12-07-41
9. Birthplece (State or Foreign Country): NC

Usuel Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: XX 1☒Yes 2☐No
10e. Street end Number: 2032 E. Lafayette Avenue Apt."B"
10f. Zip Code: 21213
10g. Citizen of What Country?: USA
11. Marital Status: XX Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade | College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: various trades
17. Father's Name (First, Middle, Last): Jack Crawford
18. Mother's Name (First, Middle, Maiden Surneme): Mary Crawford
19a. Informant's Name/Relationship (Type, Print): Linda Baker
19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 2032 E. Lafayette St. Apt."B" Baltimore, MD 21213
20a. Method of Disposition: XX 1☐ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Voshell MEm. Gardens
Date: 12-20-99
20c. Location - City or Town, State: Dundalk, MD
21. Signature of Funeral Service Licensee: Francis A Grace
22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Intervel Between Onset and Death

Immediate Ceuse (Finel diseese or condition resulting in death)
a. CORonary/artery diSEASE/Hypertension

Due to (or as a consequence of):
b. cardiac arrest

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last
Due to (or as a consequence of):
c. Diabetes, myocardial infarction hx

Due to (or as a consequence of):
d. Sleep apnea/morbid obesity

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
Hyperlipidemia
Bronchitis/Recurrent Resp. Infectims
Gouty ARTHRitis, GERD

23b. Did tobacco use contribute to the cauae of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medicel examiner? 1☐ Yes 2☒ No
26. Piece of Deeth (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28e. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physicien**: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete end piece, end due to the ceuse(s) end menner steted.

29b. Signature and title of certifier: Med MD
29c. License number: D47838
29d. Date signed (Month, Day, Year): 12/17/99

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print): Naomi Ihediohe, MD 2149 KiRK Ave. BALT. Md 21218

State Registrar

31. Date filed (Month, Day, Year): DEC 20 1999
32. Registrer's Signeture: G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires thet the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funerel director, pege 2 should be detached for use es the buriel-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39829

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SUDELLAR ELIZABETH DOZIER
2. Date of Death (Month, Day, Year): DEC. 16, 1999
3. Time of Death: 4:50 P.M.
4a. Facility Name (If not institution, give street and number): MANOR CARE NURSING HOME
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-20-8217
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 08, 1923
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3714 PARK HEIGHTS AVENUE
10f. Zip Code: 21215
10g. Citizen of What Country? USA.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 3YRS.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MACHINE OPERATOR
16b. Kind of Business/Industry: CONTINENTAL CAN CO.

17. Father's Name (First, Middle, Last): THOMAS WATSON
18. Mother's Name (First, Middle, Maiden Surname): PEARL LANE

19a. Informant's Name/Relationship (Type, Print): PHYLLIS SMITH (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3714 PARK HEIGHTS AVE, BALTIMORE, MD. 21215

20a. Method of Disposition: 1☐ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CEDAR HILL CEMETERY | Date: 12-21-99
20c. Location - City or Town, State: GLENBURNIE, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Cerebro vascular Accident — 1 Day

Due to (or as a consequence of): b. Essential Hypertension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D 30641
29d. Date signed (Month, Day, Year): December 20th 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ramesh Sabapathi Suite 308 821 N. Eutaw St Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 20 1999
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39830

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Eldridge
2. Date of Death Month Day Year: December 16, 1999
3. Time of Death: 7:15 pm
4a. Facility Name (If not institution, give street and number): Mercy Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-24-0445
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 5/16/30
9. Birthplace (State or Foreign Country): MD.

To Be Completed by Funeral Director

Usual Residence of Decadent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1033 N. Milton Ave.
10f. Zip Code: 21213
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Reca - American Indian, Black, White, etc. Specify: BLACK
15. Decedent's Edcetion (Specify only highest grade completed): Elementary/Secondery (0-12): 12th | College (1-4or 5+): N/A
16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Armed Forces
16b. Kind of Business/Industry: Army
17. Father's Name (First, Middle, Last): Leslie Eldridge
18. Mother's Name (First, Middle, Meiden Sumame): Rebecca Toney
19a. Informant's Name/Reletionship (Type, Print): Patricia Betts
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1129 N. Caroline St. Baltimore, Maryland 21213
20a. Method of Disposition: ☒ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Placa of Disposition (Name of cemetery, crematory or other place): Arbutus Mem. Pk.
Date: 12/21/99
20c. Location - Clty or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: Patricia Betts
22. Name end Address of Fecility: Betts Funeral Home 1129 N. Caroline St. Baltimore, Md. 21213

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Finai diseese or condition resulting in death)
a. Hepatocellular carcinoma — years

Due to (or as e consequence of):
b. Hepatitis B and C — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Last
Due to (or es e consequenca of):
c.
Due to (or as e consequence of):
d.

Pert II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Diabetes
Malignant fibrohistiocytoma

23b. Did tobacco use contribute to the cauae of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was en eutopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were eutopsy findings available prior to completion of ceuse of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medicel exeminer? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: ☒ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete end placa, and due to the cause(s) and manner as steted. 2 ☐ **Medical Examiner**: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Kendall Herschler MD
29c. License number: 10519
29d. Date signed (Month, Day, Year): December 16, 1999
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Kendall Herschler MD Mercy Medical Center 301 St. Paul St Balt MD

State Registrar

31. Date filed (Month, Day, Year): DEC 20 1999
32. Registrar's Signature: Jenna G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39831

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HENRY FRONCZAK

2. Date of Death: Month DECEMBER Day 14 Year 1999

3. Time of Death: 3:05pm

4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-26-4095

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 30, 1929

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 2369 Searles Road

10f. Zip Code: 21222

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2 Years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Quality Control Engineer

16b. Kind of Business/Industry: Aerospace Engineering

17. Father's Name (First, Middle, Last): Henry Frank Fronczak

18. Mother's Name (First, Middle, Maiden Surname): Pauline Rozycka

19a. Informant's Name/Relationship (Type, Print): (Wife) Mrs. Mary Ellen Fronczak

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2369 Searles Road Dundalk, Maryland 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Ht. of Jesus Cem.

Date: 12/17/1999

20c. Location - City or Town, State: Dundalk, Maryland

21. Signature of Funeral Service Licensee: Gregory E. Ruck

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ANOXIC BRAIN INJURY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. PROBABLE CARDIAC ARRYTHMIA

Due to (or as a consequence of):

c. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

CONGESTIVE HEART FAILURE

HISTORY OF MYOCARDIAL INFARCTION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ramona Gelzer Bell

29c. License number: RES-000

29d. Date signed (Month, Day, Year): DECEMBER 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAMONA GELZER BELL 6109 GOLDEN BELL WAY COLUMBIA, MD 21045

State Registrar

31. Date filed (Month, Day, Year): DEC 20 1999

32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39832

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EVELYN FRANKLIN
2. Date of Death: Month DECEMBER Day 19 Year 1999
3. Time of Death: 0625 AM
4a. Facility Name (If not institution, give street and number): NORTH WEST HOSPITAL 5401 OLD COURT RD
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 261-24-7817
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 30, 1915
9. Birthplace (State or Foreign Country): Florida

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3112 Thornfield Ave
10f. Zip Code: 21207
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): House Keeper
16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): UNK.
18. Mother's Name (First, Middle, Maiden Surname): Corrie Bell

19a. Informant's Name/Relationship (Type, Print): Calvin E. Curtis-Son in law
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3112 Thornfield Rd.Batimore,Md. 21207

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Md.Nat'l Mem./ Park
Date: 12-23-99
20c. Location - City or Town, State: Laurel Md. A.A. Co

21. Signature of Funeral Service Licensee: Lewis T.Gwynn
22. Name and Address of Facility: LewisT.Gwynn Funeral Home 4517 Parkheights AveBaltim ore,Maryland 21

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. PNEUMONIA — 4 DAYS

Due to (or as a consequence of):
b. CONGESTIVE HEART FAILURE — 4 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Samantha S. Ananth HOUSE OFFICER
29c. License number: D0053439
29d. Date signed (Month, Day, Year): DECEMBER 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAMANTHA S. ANANTH NORTHWEST HOSPITAL 5401 OLD COURT RD RANDALLSTOWN MD

State Registrar

31. Date filed (Month, Day, Year): DEC 20 1999
32. Registrar's Signature: Glenda G Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

99-7558-510
crn amend item 22 per fh G779 1/1800 99
Ricky Foreman, III
AMEND ITEMS: #23 PART I, 27, PER MEO

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

G779 1-12-2000 WR.

Certificate of Death

Reg. No. 99 39833

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ricky Foreman III

2. Date of Death Month Dey Year: December 15, 1999

3. Time of Death: 8:35 A.M.

4a Facility Name (If not institution, give street and number): St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: NA

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday) Yrs.: If Under 1 Year Months: 1 Days: 17 If Under 24 Hrs. Hours: Min.:

8. Date of Birth (Month, Day, Year): October 28, 99

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4626 Reistertown Road

10f. Zip Code: 21215

10g. Citizen of What Country? USA

11. Meritel Stetus: ☒ 1 Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementery/Secondery (0-12): N/A
College (1-4or 5+): N/A

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): N/a

16b. Kind of Business/Industry: N/A

17. Father's Neme (First, Middle, Last): Ricky Foreman Jr.

18. Mother's Neme (First, Middle, Maiden Sumame): Keisha M. Washington

19e. Inlorment's Neme/Reletionship (Type, Print): Keisha M. Washington-Mother

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 4626 Reistertown Rd., Baltimore, Md. 21215

20e. Method of Disposition: ☒ 1 Burlel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, crematory or other placa): King Memorial Park

Dete: 12/21/99

20c. Location - City or Town, Stete: Randallstown, Md

21. Signeture of Funeral Service Licensee: Dale March

22. Neme end Address of Facility: ~~Douglass Funeral Service, 1701 McCulloh St.~~ Wabash Ave. March fh West 4300 Balto. 21217 21215

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert leilure. List only one ceuse on each line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. SUDDEN INFANT DEATH SYNDROME (SIDS)

Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last

b.

Due to (or as a consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Deeth (Check only one)
Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28l. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one)
1☐ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner as steted.
2☒ **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Stephen S. Radentz, MD

29c. License number: O.C.M.E.

29d. Dete signed (Month, Day, Year): December 16, 1999

30. Neme end address of person who completed cause of death (Item 29a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year): DEC 20 1999

32. Registrer's Signeture: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

99-7055-510
crn
Craig Fox

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#23&27-28f PER M.E.O. G778 12-21-99JA

Certificate of Death

Reg. No. 99 39834

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Craig Fox	November 25, 1999	1:18 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1527 Union Avenue	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	If Under 1 Year: Days	If Under 24 Hrs.: Hours	If Under 24 Hrs.: Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
unknown	1☒M 2☐F	48 Yrs.					Aug 5, 1951	unknown

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1313 W. 37th Street	21211	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
unknown 1☐Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☐No If Yes, Give Yeer or Dates: unknown	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
unknown	unknown	unknown	unknown

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
unknown	unknown

19a. Informent's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
O.C.M.E.	111 Penn Street Baltimore, MD 21201

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Dete	20c. Location - City or Town, Stete
1☐Buriel 2☐Cremetion 3☐Removel from Stete 4☐Donetion 5☒Other (Specify) in state			

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Ronald S. Wade, Director Ronald S. Wade	State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feilure. List only one ceuse on eech line.

		Approximate Interval Between Onset end Deeth
Immediete Ceuse (Final diseese or condition resulting in deeth)	a. ACUTE ALCOHOL INTOXICATION	
	Due to (or as a consequence of):	
Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Last	b.	
	Due to (or es e consequence of):	
	c.	
	Due lo (or es a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings aveilable prior to completion of cause of death?
1☑Yes 2☐No	1☐Yes 2☐No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Wes case referred lo medical exeminer?	26. Place of Deeth (Check only one)	
1☒Yes 2☐No	Hospilel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) at scene

27. Menner of Deeth	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☐Neturel 2☐Accideni 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☒Could not be determined	FOUND 11-25-99	FOUND 1:00 P M	1☐Yes 2☒No	UNKNOWN

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)
FOUND:HOUSE	1527 UNION AVENUE BALTIMORE, MARYLAND

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted.
2☒ **Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and menner steted.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Wayne McNeil	O.C.M.E.	November 26, 1999

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print)
MARYLOUIS D. KOREIN 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrar's Signeture
DEC 20 1999	G Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

A/J

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39835

Amended Item#4a perPhyG778 12/20/99 EW

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dennis Hyner

2. Date of Death (Month, Day, Year): Nov. 07 99

3. Time of Death: 1:43pm

4a. Facility Name (If not institution, give street and number): ~~Millennium Mt. Clare Nursing Home~~ Bon Secour Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-70-6571

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 39 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept 24, 1960

9. Birthplace (State or Foreign Country): unknown

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1217 W. Fayette Street

10f. Zip Code: 21223

10g. Citizen of What Country?: USA

11. Marital Status: unknown
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No
If Yes, Give Year or Dates: unknown

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc.
Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): unknown
College (1-4or 5+): unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown

16b. Kind of Business/Industry: unknown

17. Father's Name (First, Middle, Last): unknown

18. Mother's Name (First, Middle, Maiden Surname): unknown

19a. Informant's Name/Relationship (Type, Print): Dorothy Thomas/friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 131 N. Aisquith St Baltimore, MD 21217

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify): in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS. — 1 Day

Due to (or as a consequence of):
b. End Stage HIV Disease — 3 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S Qureshi

29c. License number: D30641

29d. Data signed (Month, Day, Year): November 11 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAMESH SABBADOTH MD SUITE 308, 821 N. Eutaw St BALTIMORE MD 21201

State Registrar

31. Data filed (Month, Day, Year): DEC 20 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39836

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VIOLA HUDSON

2. Date of Death (Month, Day, Year): DEC. 14, 1999

3. Time of Death: 5:15AM

4a. Facility Name (If not institution, give street and number): CHESAPEAKE HOSPICE

4b. City, Town, or Location of Death: MILLERSVILLE

4c. County of Death: A.A. COUNTY

Funeral Director

5. Social Security Number: 219-74-9514

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC. 29, 1908

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: A.A. COUNTY

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7879 CRILLEY ROAD

10f. Zip Code: 21060

10g. Citizen of What Country? USA.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 7TH GRADE

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Neme (First, Middle, Last): GEORGE DORSEY

18. Mother's Name (First, Middle, Maiden Surname): LAURA TURNER

19a. Informant's Neme/Reletionship (Type, Print): LAVERNE HUDSON (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7809 WINDBORNE, APT. H GLEN BURNIE, MD 21060

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): HALLS CHURCH CEMETERY

Date: 12-18-99

20c. Location - City or Town, State: GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee: Joseph H. Brown

22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert tailure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediete Ceuse (Finel diseese or condition resulting in deeth)

a. Renal failure — 2wks

Due to (or as a consequence of):

b. Multiple Myeloma — 14yrs.

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospice Pt.

Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Chesapeake Hospice House

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Russell A. DeLucia, D.O.

29c. License number: 031551

29d. Date signed (Month, Day, Year): December 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Russell A. DeLucia, D.O. 600 S. Crain Highway, Glen Burnie, Md. 21061

State Registrar

31. Date filed (Month, Day, Year): DEC 20 1999

32. Registrer's Signature: Barbara G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39837

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Kwaterski
2. Date of Death (Month, Day, Year): DECEMBER 16, 1999
3. Time of Death: 3 35 PM
4a. Facility Name (If not institution, give street and number): Mercy Hospital Stella Maris Hospice
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 180-01-5792
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 14, 1914
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6812 Gough Street
10f. Zip Code: 21224
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 Years; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamtress
16b. Kind of Business/Industry: Sewing Industry

17. Father's Name (First, Middle, Last): Joseph Wyda
18. Mother's Name (First, Middle, Maiden Surname): Julia Pellish

19a. Informant's Name/Relationship (Type, Print): Patricia Furman (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1405 Delvale Avenue Dundalk, Maryland 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Stanislaus Cemetery
Date: 12/18/99
20c. Location - City or Town, State: Minersville, PA

21. Signature of Funeral Service Licensee: Stephen A Kasker
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cerebrovascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Atrial Fibrillation
Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): STELLA MARIS AT MERCY
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated.
2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: Dr A Rubenstein
29c. License number: D40854
29d. Date signed (Month, Day, Year): DECEMBER 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG, 301 St Paul Pl Baltimore MD 21202

State Registrar

31. Date filed (Month, Day, Year): DEC 20 1999
32. Registrar's Signature: B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#24a perPhyG778 12/20/99 EW

Certificate of Death

Reg. No. 99 39838

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Marjorie Munn Knapp

2. Date of Death — Month: 12 Day: 3 Year: 1999

3. Time of Death: 4:18 P.M.

4a. Facility Name *(If not institution, give street and number)*: Heron Point

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Kent

Funeral Director

5. Social Security Number: 109-16-2508

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 5-20-1920

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: MD

10b. County: Kent

10c. City, Town or Location: Chestertown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1014 Heron Point

10f. Zip Code: 21620

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 1

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: None

16b. Kind of Business/Industry: None

17. Father's Name *(First, Middle, Last)*: John R. Munn

18. Mother's Name *(First, Middle, Maiden Surname)*: Harriett Severance

19a. Informant's Name/Relationship *(Type, Print)*: Constance M. Ryan, LPN

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 501 East Campus Ave., Chestertown, MD 21620

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore St Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)

e. CHRONIC RESPIRATORY FAILURE

Due to (or as a consequenca of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as e consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: 17-13824

29d. Date signed *(Month, Day, Year)*: 12-7-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): John C Seymour, MD 122 Speer Road Suite 5 Chestertown, MD 21620

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 20 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#26 perPhyG778 12/20/99 EW

Certificate of Death

Reg. No. 99 39839

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LiLa Lee KLuGe

2. Date of Death Month Dey Year: Dec.4,1999

3. Time of Death: 7:08PM

4a. Facility Name (If not institution, give street end number): 909 Towson Dr.

4b. City, Town, or Location of Death: Abingdon

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 215-40-8893

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 56 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): Jan.11,1943

9. Birthplace (State or Foreign Country): Baltimore,MD.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Fallston

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 1316 Watervale Road

10f. Zip Code: 21047

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 12 yrs.

College (1-4or 5+): n/a

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Executive Secretary

16b. Kind of Business/Industry: Strohman's Bakery

17. Fether's Neme (First, Middle, Last): Raymond Murphy

18. Mother's Neme (First, Middle, Maiden Surname): Mary Susan Somers

19a. Informent's Neme/Reletionship (Type, Print): Mr.Brendan C. Kluge (Husband)

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 1316 Watervale Road Fallston,MD.21047

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Highview Memorial Grdns.

Dete: 12/8/99

20c. Location - City or Town, Stete: Fallston,MD.21047

21. Signeture of Funerel Service Licensee: E.F.Lassahn

22. Neme end Address of Fecility: E.F.Lassahn Funeral Home 11750 Belair Road Kingsville,MD.21087

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heert feilure. List only one ceuse on each line.

Approximete Intervel Between Onset and Deth

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. Respiratory Failure

Due to (or es e consequence of): b. Jacob Creutzfield Disease

Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or Injury thet Initieted events resulting in deeth) Last

Due to (or es e consequence of): c.

Due to (or es e consequenca of): d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveileble prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one)

Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify) Son's Home

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) and menner steted.

29b. Signeture end title of certifier: George A Oyen MD/PhD

29c. License number: MD License D0046931

29d. Date signed (Month, Dey, Yeer): 12/6/99

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): 2924 Guilford Ave, Baltimore MD 21218

State Registrar

31. Date filed (Month, Dey, Yeer): DEC 20 1999

32. Registrar's Signature: G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Li'La L. KLuge

DHMH 16 Rev 6/95

A

99-7556-510
LORRAINE KNOX
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39840

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lorraine Knox
2. Date of Death (Month, Day, Year): DECEMBER 15, 1999
3. Time of Death: 6:35 A
4a. Facility Name (If not institution, give street and number): 2620 LOYOLA SOUTHWAY
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 217-40-2891
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12 10 33
9. Birthplace (State or Foreign Country): M.D.

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 2620 Loyola South Way
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade | College (1-4or 5+): na
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Substitute Teacher
16b. Kind of Business/Industry: Balto City Schools

17. Father's Name (First, Middle, Last): James E. Knox
18. Mother's Name (First, Middle, Maiden Surname): Violia Smallwood

19a. Informant's Name/Relationship (Type, Print): James Holmes-Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 818 Unetta Ave, Baltimore Md 21229

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, cremetory or other place): Mt Zion Cemetery
Date: 12-20-99
20c. Location - City or Town, State: Lansdown, Md

21. Signature of Funeral Service Licensee: John B. Johnson Jr.
22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. EPILEPSY
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? INSPECTION 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: John Locke MD
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): DECEMBER 15, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J-Alton Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 20 1999
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

AH

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39841

Amended Item#23a perPhyG778 12/20/99 EW

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Ruth M. Lafon	November	25	99	17:11 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Montgomery General Hospital	Olney	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
226-76-0471	1☐ M 2☒ F	67 Yrs.					July 1 1932	D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Medlantic Nursing Home		Silver Springs	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2601 Belpre Road	20906	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
unknown	unknown	Housewife	own home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
unknown	unknown

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Deborah Benita/daughter	7 W. 4th Street #2 Frederick, MD 21702

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) in state			

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Ronald S. Wade, Director	State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ~~Sudden Cardiac Death~~ CHRONIC OBSTRUCTIVE PULMONARY DISEASE — mins.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. HYPERTENSION

Due to (or as a consequence of):

c. ALCOHOLIC LIVER DISEASE

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

~~COPD~~

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Suresh C. Gupta	D14876	11-29-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SURESH C. Gupta, 4701 Randolph Rd, #203, Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 20 1999	G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(A)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39842

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marion Lamartina

2. Date of Death: Month DEC Day 17 Year 99

3. Time of Death: 1420

4a. Facility Name (If not institution, give street and number): St Agnes Healthcare

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214 14 8398

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 19, 1923

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 102 N. Crain Highway Apt. 929

10f. Zip Code: 21061

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesperson

16b. Kind of Business/Industry: Dry Cleaner

17. Father's Name (First, Middle, Last): Marion Deale

18. Mother's Name (First, Middle, Maiden Surname): Dorothy Schwenke

19a. Informant's Name/Relationship (Type, Print): Linda Cavanaugh / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 514 ½ Matthews Avenue Baltimore, Maryland 21225

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp.

Date: 12/21/99

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: ▶ Donna M Braniewski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION — 4 days

Due to (or as a consequence of):

b. CARDIOGENIC SHOCK — 4 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS, CORONARY ARTERY DISEASE

END STAGE RENAL DISEASE, HYPERTENSION,

RENAL ARTERY STENOSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Joseph C. Moran resident surgery

29c. License number: P11707

29d. Date signed (Month, Day, Year): December 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSEPH C. MORAN ST. AGNES HEALTHCARE 900 CATON AVE BALTIMORE, MD 21227

State Registrar

31. Date filed (Month, Day, Year): DEC 20 1999

32. Registrar's Signature: Deputy G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME MARION L. LAMARTINA

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39843

MARIE MITCHELL December 16, 1999 5:35 p.m.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARIE C. MITCHELL
2. Date of Death (Month, Day, Year): DECEMBER 16, 1999
3. Time of Death: 5:35 P.M.
4a. Facility Name (If not institution, give street and number): STELLA MARIS HOSPICE
4b. City, Town, or Location of Death: TIMONIUM
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 217-40-9627
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 56 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3/3/43
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALDWIN
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 14203 CARROLL RIDGE COURT
10f. Zip Code: 21013
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2 YEARS
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LEGAL SECRETARY
16b. Kind of Business/Industry: LAW FIRM

17. Father's Name (First, Middle, Last): WARREN J. DAVIS
18. Mother's Name (First, Middle, Maiden Surname): MARIE B. HERMANN

19a. Informant's Name/Relationship (Type, Print): EARL W. MITCHELL HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14203 CARROLL RIDGE COURT BALDWIN, MD 21013

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARDENS OF FAITH CEM.
Date: 12/20/99
20c. Location - City or Town, State: PARKVILLE, MD

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. GLIOBLASTOMA
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D43725
29d. Date signed (Month, Day, Year): 12/17/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Date filed (Month, Day, Year): DEC 20 1999
32. Registrar's Signature: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

99-7497-510
CJ
Helen D. Meade

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39844

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Helen Virginia Meade	December 13 1999	03:24 AM.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Shock Trauma Center	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219 22 2510	1☐ M 2☒ F	77 Yrs.			June 25, 1922	West Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Baltimore	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
102 Wallace Avenue	21225	U.S.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th		File Clerk	Religious Center

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Russell David Simms	Mary Jane Boggess

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28390
Juanita Hundley / Sister	615 Bill Shaw Road Spring Lake, North Carolina

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Wallace Memorial Cemetery	12/19/99	Clintonville, W.V.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Donna M Bramicoushi	Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Injuries of Torso
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☑ Yes 2☐ No	1☑ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	12/12/99	1412 M	1☐ Yes 2☑ No	Driver of motor vehicle collided with another vehicle

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Street; Route 32	Howard County, Md

29e. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J Pestaner, M.D	O.C.M.E.	December 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 20 1999	G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

AH

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39845

CARL WILLIAM MEYER

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, MD 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): CARL WILLIAM MEYER					2. Date of Death: Month December Day 17 Year 1999			3. Time of Death: 11:40 pm
4a. Facility Name (If not institution, give street and number): Oak Crest Nursing Center			4b. City, Town, or Location of Death: Baltimore		4c. County of Death: Baltimore			
5. Social Security Number: 218-01-8936	6. Sex: 1 ☒ M 2 ☐ F	7. Age (In yrs. last birthday): 84 Yrs.	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year): Oct. 19, 1915	9. Birthplace (State or Foreign Country): Md.
Usual Residence of Decedent								
10a. State: Md.	10b. County: Baltimore	10c. City, Town or Location: Baltimore						10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 8820 Walther Blvd. Apt. 1317		10f. Zip Code: 21234					10g. Citizen of What Country? USA	
11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:					14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanical Engineer					16b. Kind of Business/Industry: BG&E	
17. Father's Name (First, Middle, Last): Carl A. Meyer					18. Mother's Name (First, Middle, Maiden Surname): Christina Margraf			
19a. Informant's Name/Relationship (Type, Print): Mrs. Viola E. Crites/friend		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8820 Walther Blvd. Apt. 1317 Baltimore, Md. 21234						
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery			Date: 12/20/99		20c. Location - City or Town, State: Woodlawn, Md.	
21. Signature of Funeral Service Licensee: [signature]		22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204						

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. END STAGE DEMENTIA	yrs.
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Kendall R Faulkner MD	D25645	12/17/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K Faulkner MD / 8800 Walther Blvd / Balto MD 21234

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 20 1999	Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39846

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joe Mitchell

2. Date of Death Month: December Day: 13 Year: 1999

3. Time of Death: 3:46 A.m

4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 705 12 1790

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 28, 1911

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 910 Victory Avenue

10f. Zip Code: 21225

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Carpenter

16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Andrew Mitchell

18. Mother's Name *(First, Middle, Maiden Surname)*: Ivy Bright

19a. Informant's Name/Relationship *(Type, Print)*: Joseph D. Mitchell

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5801 Sundown Road Laytonsville, Maryland 20882

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holly Lawn Cemetery

Date: 12/16/99

20c. Location - City or Town, State: Suffolk, Virginia

21. Signature of Funeral Service Licensee: Donna M Kramiouski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. UROSEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D43977

29d. Date signed *(Month, Day, Year)*: December 13 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ayoka Okeyenwo, 301 Hospital Drive, Glen Burnie, MD. 21061

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 20 1999

32. Registrar's Signature: Donna B Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

JOE MITCHELL

5

A14

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39847

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Jean C. Neubert

2. Dete of Deeth — Month: December; Dey: 18; Yeer: 1999

3. Time of Death: 1:00 A.M.

4a. Feciility Neme *(If not Institution, giva street and number)*: 10285 Route 108

4b. City, Town, or Location of Deeth: Columbia

4c. County of Deeth: Howard

Funeral Director

5. Sociel Security Number: 220-03-1273

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthdey)*: 95 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Yeer)*: August 10, 1904

9. Birthplece *(State or Foraign Country)*: Pennsylvania

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 10285 Route 108

10f. Zip Code: 21044

10g. Citizen of Whet Country?: United States

11. Maritel Stetus: 1☐ Naver Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No — If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16e. Decedent's Usuet Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

18b. Kind of Business/Industry: Own Home

17. Fether's Name *(First, Middle, Last)*: Joseph Pistorio

18. Mother's Name *(First, Middle, Meiden Surnema)*: Mary unknown

19e. Informent's Name/Reletionship *(Type, Print)*: Anita Raymond / daughter

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 10285 Route 108 Columbia, Maryland 21044

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or othar place)*: Crest Lawn

Dete: Dec. 21 1999

20c. Location - Clty or Town, Stete: Marriottsville, MD.

21. Signature of Funerel Servica Licensee: [signature]

22. Name and Address of Feciility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complicetions thet caused tha death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Intervel Between Onset end Deeth

Immediate Ceuse (Finel diseese or condition resulting in death): e. Chronic obstructive lung disease — Approximate Intervel: years

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in daath) Lest:

b. Asthma

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other signficant conditions** contributing to death but not rasulting in the underlying ceuse given in Pert f.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes casa referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 8☐ Othar *(Specify)*

27. Memner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physicien**: To the best of my knowledge, death occurred et the time, dete end plece, end dua to the ceuse(s) end menner as steted. 2☐ **Medical Examfner**: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner steted.

29b. Signature end title of certifier: [signature]

29c. License number: D004345

29d. Date signed *(Month, Dey, Yaer)*: December 20, 1999

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Charles E. Taylor MD 2 Knoll North Drive, Columbia MD 21045

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 20 1999

32. Registrar's Signeture: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with tha Maryland Department of Health and Mental Hygiena.

Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Funeral Director: Aftar this certificata has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To the Hospital or Attending Physician: The law requiras that the death certificate be executed within 24 hours after death.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39848

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Darylanne Oplinger

2. Dete of Deeth — Month: December Dey: 17, Yeer: 1999

3. Time of Death: 5:10 P.M.

4a. Feclity Neme (If not institution, give street end number): 9349 Afternoon Lane

4b. City, Town, or Location of Deeth: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 167-48-0806

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. lest birthday): 43 Yrs.

If Under 1 Yaar — Months: Deys: If Under 24 Hrs. — Hours: Min.:

8. Date of Birth (Month, Dey, Year): Oct. 27, 1956

9. Birthplece (Stete or Foraign Country): Michigan

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street end Number: 9349 Afternoon Lane

10f. Zip Code: 21045

10g. Citizen of Whet Country?: United States

11. Maritel Status: 1☐ Navar Marriad 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedant Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Give Year or Dates:

13. Was Decedant of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indian, Bleck, Whita, etc. Specify: white

15. Decedent's Eaucation (Specify only highest grede completed) — Elementery/Secondery (0-12): 12 — College (1-4or 5+): 2

16a. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa ratired): Catering Consultant

16b. Kind of Business/Industry: Catering

17. Fether's Nama (First, Middle, Last): Charles E. Foust

18. Mothar's Nama (First, Middla, Maiden Surneme): Elizabeth Arnold

19a. Informent's Name/Reletionship (Type, Print): Willard Oplinger / spouse

19b. Mailing Address (Street end Numbar or Rurel Route Number, City or Town, Stete, Zip Coda): 9349 Afternoon Lane Columbia, Maryland 21045

20a. Mathod of Disposition: 1☐ Burial 2☒ Crametion 3☐ Removal from Stata 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other piece): Metro Crematory

Date: Dec. 20 1999

20c. Location - City or Town, Stete: Catonsville, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Nama and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that causad the death. Do not entar tha moda of dying, such as cardiac or raspiratory errest, shock, or heert failure. List only ona causa on each line.

Approximete Interval Betwaan Onset end Deeth

Immediate Ceuse (Finel disease or condition resulting in deeth)

a. Metastatic Pancreatic Cancer to Liver — 18months

Due to (or as a consaquanca of):

Sequentially list conditions, if eny, laading to immediata ceusa. Entar Underlying Cause (Disaasa or Injury thet initiated events resulting in deeth) Lest

b.

Due to (or es e consaquance of):

c.

Due to (or as e consequence of):

d.

Part II. **Other aignificant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco uae contribute to the ceuse of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1☐ Yas 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifiar (Check only one): 1☑ **Certifying Physician:** To the best of my knowledga, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred et the time, dete end place, and due to the ceuse(s) end manner stetad.

29b. Signetura and title of certifiar: Nicholas Jul Routrelakos

29c. License number: D38509

29d. Deta signad (Month, Day, Year): December 20 1999

30. Nama end addrass of person who completed ceuse of death (Item 23e) (Type, Print): Nicholas Jul Routrelakos 11065 Little Patuxent Pky Columbia MD 21044

State Registrar

31. Dete filed (Month, Day, Year): DEC 20 1999

32. Registrar's Signatura: [signature] G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours eftar death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours eftar death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as tha burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39849

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EUGENE PANNONE
2. Data of Death Month: DECEMBER Day: 07 Yaar: 1999
3. Time of Death: 7:05pm
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-14-5546
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 75 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 8,1924
9. Birthplaca (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stata: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 2107 Jasmine Road
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Giva Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 Years; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Diesel Mechanic
16b. Kind of Business/Industry: Railroad

17. Father's Nama (First, Middle, Last): Francesco Pannone
18. Molher's Name (First, Middle, Maiden Surneme): Maria Couzzo

19a. Informant's Name/Ralationship (Type, Print): Mr. Eugene J. Pannone (Son)
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 509 Crisfield Road Baltimore, Maryland 21220

20a. Method of Disposition: 1☐ Burial 2☐ Cremetion 3☐ Removal from Stata 4☐ Donation 5☒ Other (Specify) Entombment
20b. Place of Disposition (Name of cemetery, crematory or othar place): Holly Hill Mausoleum
Data: 2/11/1999
20c. Location - City or Town, Stete: Middle River, MD

21. Signature of Funeral Service Licensee: Gregg E. Ruck
22. Name and Addrass of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on eech line.

Approximate Interval Batween Onset end Daath

Immediata Cause (Finet disease or condition resulting in death): a. CEREBROVASCULAR ACCIDENT — 2DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or es a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Ware eutopsy findings availabla prior to complation of cause of daath? 1☐ Yes 2☒ No

25. Was casa relarred to medical examiner? 1☐ Yes 2☒ No

26. Placa of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be detarmined

28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Dascribe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at tha time, dete end plece, end due to tha causa(s) and manner es steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or invastigation, in my opinion, death occurred at the tima, data and placa, and dua to tha cause(s) and manner steted.

29b. Signatura and litla of certifier: JOZR. Schilling
29c. License number: RES-099
29d. Data signed (Month, Day, Year): DECEMBER 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John K. Schilling Johns Hopkins Bayview Hospital Baltimore, Md 21224

State Registrar

31. Date filed (Month, Day, Year): DEC 20 1999
32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39850

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROSELLA THELMA PRINGLE
2. Date of Death (Month, Day, Year): DEC. 16, 1999
3. Time of Death: 2:00 AM
4a. Facility Name (If not institution, give street and number): 711 DEACON HILL COURT
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-26-2224
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth (Month, Day, Year): JAN. 23, 1920
9. Birthplace (State or Foreign Country): SOUTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 711 DEACON HILL COURT
10f. Zip Code: 21225
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4or 5+): 1 YR.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): MELVIN ROLLERSON
18. Mother's Name (First, Middle, Maiden Surname): LUCINDA MCDONALD

19a. Informant's Name/Relationship (Type, Print): DOROTHY BELL (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2855 SEAMON AVENUE, BALTIMORE, MD. 21225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CEDAR HILL CEMETERY
Date: 12-21-99
20c. Location - City or Town, State: GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Adenocarcinoma — 1 month
Due to (or as a consequence of):
b. liver metastasis of
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Unknown Primary
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D 39041
29d. Date signed (Month, Day, Year): December 16 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GAYATRI NIMMAGADDA 3001 S. Hanover Street Harbor Hospital Center Baltimore MD 21225

State Registrar

31. Date filed (Month, Day, Year): DEC 20 1999
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39851

PATIENT KNOWN AS IRENE PINCKNEY

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): IRENE PINCKNEY

2. Date of Death Month 12 Day 18 Year 1999

3. Time of Death 10:48 AM

4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 226 07 6011

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 06-01-1913

9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 217 ALLENDALE ST.

10f. Zip Code: 21229

10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yas 2☒ No If Yas, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elemantary/Secondary (0-12): 6 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DOMESTIC

16b. Kind of Business/Industry: HOME

17. Father's Neme (First, Middle, Last): PETER DODSON

18. Mother's Name (First, Middle, Maiden Surneme): HATTIE CRAWLEY

19e. Informant's Neme/Reletionship (Type, Print): JUNIOUS DODSON /SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 217 ALLENDALE ST. BALTO., MD. 21229

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetary, crematory or other piece): WESTERN STAR

Dete: 12/22/99

20c. Location - City or Town, State: BALTO., MD.

21. Signature of Funeral Service Licensee: James A. Morton

22. Name and Address of Facility: JAMES A. MORTON & SONS FUNERAL HOMES, INC. 1701 LAURENS ST. BALTO., MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart faitura. List only one cause on each line.

Approximate Intervel Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Cause (Disease or Injury thet initieted evants resulting in death) Last

b. MYOCARDIAL INFARCTION

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ANEMIA

SACRAL DECUBITIS STAGE IV

23b. Did tobacco use contribute to the ceuse of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Wes case refarred to medicat examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residance 6☐ Other (Specify)

27. Mannar of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the tima, data and place, and dua to tha causa(s) and mannar es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et tha time, data and piece, end due to the ceusa(s) end manner steted.

29b. Signature and title of certifier: [signature]

29c. License number: REG 0000

29d. Date signed (Month, Dey, Year): December 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MD MENNETTE 2401 W. BELVEDERE BALTIMORE MD 21215

State Registrar

31. Dete filed (Month, Day, Year): DEC 20 1999

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39852

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MILDRED A. PULLEY
2. Date of Death: Month 12 Day 10 Year 1999
3. Time of Death: 4:50 AM
4e. Facility Name (If not institution, give street and number): Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annaplis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 214-12-1569
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 25, 1919
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Annaplis
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 68 Clay Street
10f. Zip Code: 21401
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): laundry attendant/cashier
16b. Kind of Business/Industry: hotel

17. Father's Name (First, Middle, Last): Vachael Ashbury Harris
18. Mother's Name (First, Middle, Maiden Surname): Amelia Minnie Martin

19a. Informant's Name/Relationship (Type, Print): Bernadette Pruitt/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 68 Clay St Annaplis, MD 21401

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. CONGESTIVE HEART FAILURE	3 yrs
Due to (or as a consequence of):	CARDIOMYOPATHY	3 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): HYPERTENSION	10 yrs
	c. Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
COPD
RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Donald C. Rowe, M.D.
29c. License number: D10698
29d. Date signed (Month, Day, Year): 12-10-1999

30. Name and address of person who completed cause of death (item 23a) (Type, Print): Donald C. Rowe, MD 16/6 Forest Drive Annapolis 21403

State Registrar

31. Date filed (Month, Day, Year): DEC 20 1999
32. Registrar's Signature: Jenna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39853

Physician-/Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Frederick John Reinhard Sr.

2. Date of Death (Month, Day, Year): December 16, 1999

3. Time of Death: 1102 pm

4a. Facility Name *(If not institution, give street and number)*: Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219 30 2134

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 64 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 16, 1935

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10e. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2307 Washington Blvd.

10f. Zip Code: 21230

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: Trucking Company

17. Father's Neme *(First, Middle, Last)*: Ernest Reinhard

18. Mother's Name *(First, Middle, Meiden Surneme)*: Catherine Garrity

19e. Informent's Name/Relationship *(Type, Print)*: Patricia Reinhard / Wife

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 2307 Washington Blvd. Baltimore, Maryland 21230

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other place)*: Glen Haven Memorial Park

Date: 12/21/99

20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: Donna M Bromirowski

22. Neme and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immedlete Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

b. Coronary Artery Disease

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Respiratory Failure

Due to (or as a consequence of):

d. Chronic Obstructive Pulmonary Disease

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Deeth *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of fnjury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physicfan:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner as stated. 2☐ **Medicat Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signeture and title of certifier: Anila Bhatti M.D

29c. License number: 89345

29d. Dete signed *(Month, Dey, Year)*: 12/14/99

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Anila Bhatti, M.D. Go Maryland General Hospital

State Registrar

31. Date filed *(Month, Dey, Year)*: DEC 20 1999

32. Registrar's Signature: [illegible] Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Frederick Reinhard

A-1

99-7436-510
DDG
CARL SHEPARD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39855

Physician / Medical Examiner

1. Decedent's Name (First, Middle, Last): Carl Sheppard JR.
2. Data of Death (Month, Day, Yaar): DECEMBER 10, 1999
3. Tima of Death: 0950 AM
4a. Facility Name (If not institution, give street and number): UNION MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 214-50-2652
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 50 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): 2/11/49
9. Birthplace (State or Foraign Country): N.C.

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Insida City Limits: 1 ☒ Yas 2 ☐ No
10e. Street and Number: 1410 N. Gay St.
10f. Zip Code: 21213
10g. Citizan of Whet Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- II Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - Amarican Indian, Black, Whita, atc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Steel Worker
16b. Kind of Business/Industry: Bethlehem Steel

17. Father's Nama (First, Middle, Last): Carl Sheppard Sr.
18. Mothar's Nama (First, Middle, Maiden Sumama): Beatrice Dew

19a. Informant's Name/Relationship (Type, Print): Beatrice Sheppard
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 1410 N. Gay St. Baltimore, Maryland 21213

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Nama of cemetery, crematory or other place): Mt. Zion Cemetary | Data: 12-17-99
20c. Location - City or Town, Stata: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Valerie Betts
22. Nama and Address of Facility: Betts Funeral Home 1129 N. Caroline St. Baltimore, Md. 21213

Physician / Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. (Approximata Intarval Betwaen Onsat and Daath)

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic Cardiovascular Disease
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.: Chronic Renal Failure

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Wes an autopsy performed? 1 ☐ Yas 2 ☒ No
24b. Ware autopsy findings availeble prior to complation of causa of daath? 1 ☐ Yas 2 ☒ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only ona): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Othar (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1 ☐ Yas 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, data and place, and dua to tha causa(s) and mannar as stated. 2 ☒ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, deeth occurred at the tima, date end place, and due to tha causa(s) and manner stated.
29b. Signature and title of certifier: Lawrence MD
29c. License number: O.C.M.E.
29d. Data signad (Month, Day, Year): DECEMBER 10, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. LAWRENCE LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 20 1999
32. Registrar's Signatura: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39854

AMENDED ITEMS #7,17,18,19b-22 PER FH G779 1/19/2000 AH

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Shirley Roberts

2. Date of Death: Month 12 Day 14 Year 99

3. Time of Death: 6:30A

4a. Facility Name (If not institution, give street and number): LONG Green NSG CENTER

4b. City, Town, or Location of Death: BALTO.

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-54-1489

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 63 ~~83~~ Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan 3, 1936

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1415 W. Baltimore Street

10f. Zip Code: 21223

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): domestic work/dishwasher

16b. Kind of Business/Industry: housekeeping

17. Father's Name (First, Middle, Last): ~~unknown~~ FRANK MISTER

18. Mother's Name (First, Middle, Maiden Surname): ~~unknown~~ ELIZABETH HOOPER

19a. Informant's Name/Relationship (Type, Print): Patricia Austin/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): ~~unknown~~ 2103 N CHARLES STREET APT. #2

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ ~~Other (Specify)~~ in state

20b. Place of Disposition (Name of cemetery, crematory or other place): NEW CATHEDRAL CEMETERY

Date: 12/21/99

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: ~~Ronald B. Wade, Director~~ BERNARD JOHNSON

22. Name and Address of Facility: ~~State Anatomy Board 655 W. Baltimore Street Baltimore, MD 2120?~~ WM C MARCH FUNERAL HOME 1101 E NORTH AVE., BALTO., MD 21202

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Silent Arrhythmia — Minutes

Due to (or as a consequence of):
b. Atherosclerotic Coronary Artery Disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure
End Stage Renal Disease
Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD Attending

29c. License number: D17118

29d. Date signed (Month, Day, Year): Dec 14, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL SCHWARTZ MD 115 E. Melrose Ave 21212

State Registrar

31. Date filed (Month, Day, Year): DEC 20 1999

32. Registrar's Signature: G Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39856

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Betty Smith
2. Date of Death: Month December Day 13 Year 1999
3. Time of Death: 11:20 PM
4a. Facility Name (If not institution, give street end number): Good Samaritan Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: UNKNOWN
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 53 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC. 25, 1945
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3701 TWIN LAKES COURT
10f. Zip Code: 21244
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE | College (1-4or 5+): 2 YRS
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ASSISTED LIVING MANAGER
16b. Kind of Business/Industry: BATEMAN HOUSE

17. Father's Name (First, Middle, Last): LONNIE HENDERSON
18. Mother's Name (First, Middle, Maiden Surname): MARY MARTHA MACEY

19a. Informant's Name/Relationship (Type, Print): MARY MARTHA BANKS (MOTHER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3701 TWIN LAKES CT., APT. 409, BALTIMORE, MD. 21244

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY
Date: 12-16-99
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Sudden Death
Due to (or as a consequence of):
b. Probable Acute Myocardial Infarction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Asthma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Wayne S. Barry
29c. License number: D 18009
29d. Date signed (Month, Day, Year): December 14, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Wayne S. Barry, MD, Good Samaritan Hospital of Baltimore

State Registrar

31. Date filed (Month, Day, Year): DEC 20 1999
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020
Division of Vital Records, P.O. Box 68760,

Betty Smith
2
AA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39857

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HARRY SPROUSE
2. Date of Death (Month, Day, Year): DECEMBER 13 1999
3. Time of Death: 2:40 PM
4a. Facility Name (If not institution, give street and number): MERCY HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 231-32-2538
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 70 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAR. 12, 1929
9. Birthplace (State or Foreign Country): VA.

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 405 S. NEWKIRK ST.
10f. Zip Code: 21224
10g. Citizen of What Country: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 1948-52 WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 TH; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ASSEMBLY WORKER
16b. Kind of Business/Industry: GENERAL MOTORS

17. Father's Name (First, Middle, Last): ALONZO SPROUSE
18. Mother's Name (First, Middle, Maiden Surname): HESTER COLEMAN

19a. Informant's Name/Reletionship (Type, Print): BERTHA MARY SPROUSE/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 405 S. NEWKIRK ST., BALTIMORE, MD. 21224

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): BALTIMORE WASHINGTON
Date: 12/16/99
20c. Location - City or Town, State: LAUREL, MD.

21. Signature of Funeral Service Licensee: Elizabeth Selenski
22. Name and Address of Facility: CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Laryngeal Cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): STELLA MARIS AT MERCY
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) HOSPICE

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: D L Rusnock MD
29c. License number: D40854
29d. Date signed (Month, Day, Year): DECEMBER 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl Baltimore MD 21202

State Registrar

31. Date filed (Month, Day, Year): DEC 20 1999
32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39858

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edward L. Style

2. Date of Death Month / Day / Year: DECEMBER 16, 1999

3. Time of Death: 10 P.M

4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 214 03 4522

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 16, 1918

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7712 Stoney Creek Drive

10f. Zip Code: 21122

10g. Citizen of What Country?: U.S.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: W.W. II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk

16b. Kind of Business/Industry: Social Security Adm.

17. Father's Name *(First, Middle, Last)*: James Style

18. Mother's Name *(First, Middle, Maiden Surname)*: Antonia Lubawa

19a. Informant's Name/Relationship *(Type, Print)*: Elizabeth Style / Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 181 South 17th Street Pittsburgh, Pennsylvania 15203

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Md. State Veteran Cem.

Date: 12/20/99

20c. Location - City or Town, State: Crownsville, Maryland

21. Signature of Funeral Service Licensee: Donna M Zramiewski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA
SEPSIS
RENAL FAILURE (Pt was on Hemodialysis)
OCD CVA
Prosthetic Aortic Valve replacement

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D51245

29d. Date signed *(Month, Day, Year)*: December 16, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): SAJID SHARIF NORTH ARUNDEL HOSPITAL - MD

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 20 1999

32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Style, Edward L

67

A17

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39859

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RAYMOND J. SARZYNSKI
2. Date of Death (Month, Day, Year): DEC. 14, 1999
3. Time of Death: 1232
4e. Facility Name *(If not institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 219-14-1288
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 2/5/25
9. Birthplace *(State or Foreign Country)*: MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: WORCHESTER
10c. City, Town or Location: OCEAN CITY
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 404 YAWL ROAD
10f. Zip Code: 21842
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 | College (1-4or 5+): 0
16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CARPENTER/ TRADESMAN
16b. Kind of Business/Industry: FURNITURE
17. Father's Name *(First, Middle, Last)*: JOSEPH SARZYNSKI
18. Mother's Name *(First, Middle, Maiden Surname)*: MARY BOSA
19a. Informant's Name/Relationship *(Type, Print)*: MRS. LILLIAN SARZYNSKI
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 404 YAWL RD. OCEAN CITY, MD. 21842
20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: ST. STANISLAUS CEME. Date: 12/17
20c. Location - City or Town, State: DUNDALK , MD.
21. Signature of Funeral Service Licensee: Eugene J. Kaczorowski
22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME P.A. 1201 DUNDALK AVE. BALTO., MD. 21222

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Ischemic Heart Disease — 3yr

Due to (or as a consequence of): b. Colon Ca — 4mo

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐Yes 2☒No

25. Was cese referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steted. 2☐**Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end menner stated.

29b. Signeture and title of certifier: J. Grass
29c. License number: D 20507
29d. Date signed *(Month, Dey, Yeer)*: 12/14/99

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): JOSEPH A. GRASSO 145 E. Cannon St. Salisbury MD

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 20 1999
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6x1

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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39860

Amended Item#24a,26,29a perPhyG778 12/20/99 EW

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Washington I Tuttles IV

2. Date of Death: Month November Day 26 Year 99

3. Time of Death: 7:20 AM

4a. Facility Name (If not institution, give street and number): 100 Davidson Lane

4b. City, Town, or Location of Death: Queenstown

4c. County of Death: Queen Annes

Funeral Director

5. Social Security Number: 214-18-4395

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 75 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan 16, 1924

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Queen Annes

10c. City, Town or Location: Queenstown

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 100 Davidson Lane

10f. Zip Code: 21658

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: home improvements

17. Father's Name (First, Middle, Last): Washington Tuttles III

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Bishop

19a. Informant's Name/Relationship (Type, Print): John Tuttles/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 500 Waverly Lane Centerville, MD 21617

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Respiratory Failure

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

b. Motor Neuron Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings availeble prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medicel examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end pleca, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Terry Detrich

29c. License number: D12893

29d. Date signed (Month, Dey, Year): 12-6-99

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Terry Detrich, 140 S. Washington St, Easton, MD 21601

State Registrar

31. Date filed (Month, Dey, Year): DEC 20 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39861

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERTA TATE

2. Date of Death: Month DEC Day 17 Year 1999

3. Time of Death: 0135 Am

4e. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 240-46-4079

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 20, 1923

9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10e. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2035 N. McCULLOH STREET

10f. Zip Code: 21217

10g. Citizen of What Country? USA.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4or 5+):

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DOMESTIC WORKER

16b. Kind of Business/Industry: PRIVATES HOMES

17. Father's Name (First, Middle, Last): UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname): UNKNOWN

19e. Informant's Name/Relationship (Type, Print): ERNEST MORRIS (FRIEND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3808 FERNHILL AVENUE, BALTIMORE, MD. 21215

20e. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY

Date: 12-22-99

20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: C. D. Brown

22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Ischemic bowel	1 day
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Atherosclerosis	10 years
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Deep vein thrombosis and pulmonary embolism

Pelvic fracture

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D41836

29d. Date signed (Month, Day, Year): Dec 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 4713 Leeds Avenue Balt. MD 21227

State Registrar

31. Date filed (Month, Day, Year): DEC 20 1999

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39862

Certificate of Death

Reg. No.

Amended Item#17 perFH G778 12/20/99 EW

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Paul I Tunstall

2. Dete of Death Month: December Dey: 12 Year: 1999

3. Time of Death: 11:54pm

4e Facility Neme (If not institution, give street end number): Sinai Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 223-20-3803

6. Sex: XX M 2☐ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Deta of Birth (Month, Day, Year): 04 29 21

9. Birthplace (State or Foraign Country): V.A.

Usual Residence of Decedent

10a. Stete: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4223 Fords Lane

10f. Zip Code: 21215

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1☐ Never Merried XX Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes XX No Specify:

14. Race - American Indien, Black, White, atc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9th grade

College (1-4or 5+): na

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Business Owner

16b. Kind of Business/Industry: Self Employed

17. Fether's Neme (First, Middle, Last): Orlando ~~Isiah~~ Tunstall

18. Mother's Name (First, Middle, Maiden Sumeme): Emma Harper

19a. Informent's Neme/Reletionship (Type, Print): Paul Tunstall-Son

19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code): 19705 116th Avenue, Saint Albans, N.Y. 11412

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from Stata 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc

Dete: 12/20/99

20c. Location - City or Town, Stete: Baltimore, Md

21. Signature of Funeral Service Licensee: John B. Johnson

22. Name end Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not entar the mode of dying, such as cardiac or raspiratory errast, shock, or heart tailure. List only ona cause on aach lina.

Approximete Intervel Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death): e. Sepsis — weeks

Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b. Due to (or es e consequenca of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Pert I.

- Diabetes
- End stage renal disease

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one) Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, streat, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledge, daath occurred at the time, date and place, end due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Frances E. Williams, MD

29c. License number: P10441

29d. Date signed (Month, Day, Year): December 12, 1999

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Frances E. Williams, MD Sinai Hospital 2401 W. Belvedere Ave Baltimore, MD 21215

State Registrar

31. Date filed (Month, Day, Year): DEC 20 1999

32. Registrar's Signeture: Geneva G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

AH

ORIGINAL

99-7433-005
DDG
SANDRA WILLIAMS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, II, 27 PER MEO 6779 12-5-2000 WR.

Certificate of Death

Reg. No. 99 39863

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Data of Death Month Day Year	3. Time of Death
Sandra	Williams	DECEMBER 10, 1999	0748 AM

4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1612 FOUR GEORGES COURT APARTMENT 4B	DUNDALK	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-86-9772	1☐ M 2☒ F	32 Yrs.			Aug. 20,1967	Unknown

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Dundalk	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1612 Four Georges Ct. Apt.4B	21222	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
Unknown		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Unknown	Unknown

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Judith Schagrin(Social Worker)	One Investment Place Towson, Maryland 21204

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Data	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	St. Matthews Cemetery	12/15/99	Baltimore, Maryland

21. Signature of Funeral Service Licensee: Megan E Ruck

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line. — Approximate Interval Batwaen Onsat and Death

Immediate Cause (Final diseasa or condition resulting in death): a. ASTHMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.: GRAVES DISEASE; HEPATITIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Ware autopsy findings available prior to complation of causa of death?
1☒ Yas 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Othar (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, date and place, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Data signed (Month, Day, Year)
J. Lalon Locke MD	).C.M.E.	DECEMBER 10, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. LALON LOCKE MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signature
DEC 20 1999	Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39864

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Florence Welsh

2. Date of Death (Month, Day, Year): December 15, 1999

3. Time of Death: 1400

4a. Facility Name (If not institution, give street and number): THE Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore, City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-12-5814

6. Sex: 1☐ M 2☒ F

7. Age (In yrs/ last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 23, 1922

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Edgemere

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2520 North Snyder Avenue

10f. Zip Code: 21219

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 1 Year

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Real Estate Agent

16b. Kind of Business/Industry: Real Estate

17. Father's Name (First, Middle, Last): Walter G. Reames

18. Mother's Name (First, Middle, Maiden Surname): Willie Mae Holland

19a. Informant's Name/Relationship (Type, Print): Mr. John C. Welsh, Sr. (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2520 North Snyder Avenue Edgemere, MD 21219

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery

Date: 12/18/1999

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Gregg E Reed

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. acute myocardial infarction — 16 hours

Due to (or as a consequence of):

b. coronary artery disease — 4 years

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert Roberts MD

29c. License number: RES-000

29d. Date signed (Month, Day, Year): December 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Roberts - Johns Hopkins Hospital 600 North Wolfe Street Baltimore, Maryland 21287

State Registrar

31. Date filed (Month, Day, Year): DEC 20 1999

32. Registrar's Signature: Geneva P Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39865

NAME KNOWN TO PHYSICIAN: JOHN L. WEBER
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name *(First, Middle, Last)*: John Leroy Weber
2. Date of Death (Month, Day, Year): December 16, 1999
3. Time of Death: 04:00AM
4a. Facility Name *(If not institution, give street and number)*: VA Maryland Health Care System
4b. City, Town, or Location of Death: Perry Point
4c. County of Death: Cecil
5. Social Security Number: 218-03-2261
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 29, 1919
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8185 Park Haven Road
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Datas: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 Years; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Police Department
16b. Kind of Business/Industry: Baltimore City

17. Father's Name *(First, Middle, Last)*: William Weber
18. Mother's Name *(First, Middle, Maiden Surname)*: Irene Conn

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Dorothy Weber (Wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8185 Park Haven Road Dundalk, Maryland 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Sacred Ht. of Jesus Cem.
Date: 12/20/99
20c. Location - City or Town, State: Dundalk, Maryland

21. Signature of Funeral Service Licensee: Gregory E Reed
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc
7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung cancer — unknown

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rmathur
29c. License number: D39170
29d. Date signed *(Month, Day, Year)*: December 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAKESH MATHUR, M.D., VA Maryland Health Care System, Perry Point, MD 21902

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 20 1999
32. Registrar's Signature: Denise G Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39866

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mathew E. White
2. Date of Death Month / Day / Year: 12-15-99
3. Time of Death: 9:00PM
4a. Facility Name *(If not institution, give street and number)*: Dulaney Towson Health Care Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-16-8410
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 01-01-18
9. Birthplace *(State or Foreign Country)*: Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 12216 Eastern Avenue
10f. Zip Code: 21220
10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Second Grade; College (1-4or 5+): N/A
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer
16b. Kind of Business/Industry: Steel Industry

17. Father's Neme *(First, Middle, Last)*: Steven White
18. Mother's Name *(First, Middle, Maiden Surneme)*: Celia White

19a. Informant's Neme/Reletionship *(Type, Print)*: Steven L. White/Son
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 130 Laburnum Road Edgewood, Maryland 21040

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Sharp St. Church Cemetery — Dete: 12-20
20c. Location - City or Town, Stete: Chase, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name end Address of Fecility: William C. Brown Community Funeral Home, Harford 321 Philadelphia Blvd., South Aberdeen, MD 21001

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximele Interval Between Onset and Death
Immediete Cause (Finat diseese or condition resulting in death)	e. Cerebral Vascular Accident	2 months
	Due to (or es e consequenca of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last	b.	
	Due to (or es a consequenca of):	
	c.	
	Due to (or es e consequenca of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Wes en autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Wes case referred to medicat examiner? 1 ☐ Yes 2 ☑ No
26. Place of Deeth *(Check only one)*: Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☑ Nursing Home 5 ☐ Residence 8 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end pleca, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: [signature] Attending Physician
29c. License number: D53642
29d. Date signed *(Month, Dey, Year)*: Dec 16 1999

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): X/AO M 2H04 3007 E Northern Parkway Baltimore 21214

State Registrar

31. Dete filed *(Month, Bay, Year)*: DEC 20 1999
32. Registrar's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39867

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lillian M. White

2. Date of Death: Month December Day 14 Year 1999

3. Time of Death: 5.25A

4a. Facility Name (If not institution, give street and number): NORTH Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 214 14 0042

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 11, 1922

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Riviera Beach

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 184 Kenwood Road

10f. Zip Code: 21122

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Switchboard Operator

16b. Kind of Business/Industry: Md. Shipbuilding

17. Father's Name (First, Middle, Last): Avery Gordy

18. Mother's Name (First, Middle, Maiden Surname): Mable Councilman

19a. Informant's Name/Relationship (Type, Print): Carol Hearrell / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 29741 Mingle Wood Lane Fammington Hills, Mich. 48334

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Memorial Park

Date: 12/22/99

20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: Gregory Gonce

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS

Due to (or as a consequence of):
b. PNEUMONIA.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. RESPIRATORY FAILURE

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D45149

29d. Date signed (Month, Day, Year): December 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ONABAJO 301 HOSPITAL DRIVE GLEN BURNIE MD 21061

State Registrar

31. Date filed (Month, Day, Year): DEC 20 1999

32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

White, Lillian

10

AH

99-7281-005 AMEND#23&27-28f PER M.E.O. G778 12-21-99 J.A.

B.K.S

RONALD D. ZIEGLER

AMENDED ITEM #8 PER AB G778 12/20/99 AH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 39868
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ronald D. Ziegler
2. Data of Death (Month, Day, Year): DEC. 3, 1999
3. Time of Death: 2011 PM
4a. Facility Name (If not institution, give street and number): 3508 WHEELHOUSE ROAD
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-52-5113
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 49 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): 10/12/50
9. Birthplace (State or Foraign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3508 Wheelhouse Road
10f. Zip Code: 21220
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yas, Giva Year or Datas: unknown
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:
14. Raca - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown | College (1-4or 5+): unknown
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): disabled
16b. Kind of Business/Industry: none

17. Father's Name (First, Middle, Last): Alvin Ziegler
18. Mother's Nama (First, Middle, Maiden Surnama): Dorothy

19a. Informant's Name/Relationship (Type, Print): Carol Wanek/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 407 Haslett Rd Joppa, MD 21085

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from Stata 4☒ Donation 5☐ Other (Specify)
20b. Placa of Disposition (Nama of cematary, crematory or other place)
Data
20c. Location - City or Town, Stata

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Nama and Address of Facility: State Anatomy Board 655 W. Baltimore St Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on aach lina.

Approximata Intarval Batwaen Onset and Death

Immediata Cause (Final disease or condition resulting in death): a. NARCOTIC INTOXICATION

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Dua to (or as a consequence of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referrad to medical examiner? 1☒ Yes 2☐ No

26. Placa of Death (Check only ona): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Homa 5☒ Residanca 6☐ Othar (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be datarmined

28a. Data of Injury (Month, Day Year): FOUND 12-3-99
28b. Time of Injury: FOUND 7:50 P M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: UNKNOWN
28e. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify): FOUND AT HOME
28f. Location (Street and Number or Rural Route Number, City or Town, Stata): 3508 WHEELHOUSE RD. BALTO. CO., MD.

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To tha best of my knowledga, death occurrad at the time, data and placa, and due to tha causa(s) and mannar as stated. 2☒ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurrad at tha time, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signature and title of certifier: Theodore McKing, M.D.
29c. License number: O.C.M.E
29d. Data signed (Month, Day, Year): DEC. 4. 1999

30. Name and address of person who completed causa of daath (Item 23a) (Type, Print): THEODORE McKING 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year): DEC 20 1999
32. Registrar's Signatura: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39869

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HELEN AYRES
2. Date of Death Month/Day/Year: December 17, 1999
3. Time of Death: 6:18 pm
4a. Facility Name (If not institution, give street and number): Vantage House
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 295-03-9957
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 8, 1915
9. Birthplace (State or Foreign Country): Minnesota

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5400 Vantage Point RD, Apt 905
10f. Zip Code: 21044
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Frank Coventry
18. Mother's Name (First, Middle, Maiden Surname): Josie Roberts

19a. Informant's Name/Relationship (Type, Print): William H. Ayres, husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21044: 5400 Vantage Point Rd., Apt. 905, Columbia, MD

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, cremetory or other piece): Baltimore/Wash. Crematory | Data: 12/22/99
20c. Location - City or Town, State: Laurel, Md.

21. Signature of Funeral Service Licensee: Sandra L Lemmer
22. Name and Address of Facility: Witzke Funeral Home, Inc. 5555 Twin Knolls Rd., Columbia, Md. 21045

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. End Stage Renal Disease	5 years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William Flowers MD
29c. License number: D20789
29d. Date signed (Month, Day, Year): December 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Flowers MD 11055 Little Patuxent Columbia MD

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

MD LMTZ

A47

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39870

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Aubra Allen
2. Date of Death — Month: Dec. Day: 18, Year: 1999
3. Time of Death: 2:30AM
4e. Facility Name (If not institution, give street and number): 1401 Alexis Dr.
4b. City, Town, or Location of Death: Joppa
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 217-40-2381
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 57 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 14,1942
9. Birthplace (State or Foreign Country): Kentucky

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Joppa
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1401 Alexis Drive
10f. Zip Code: 21085
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: ARMY 1959-62
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs. College (1-4or 5+): n/a
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Printer
16b. Kind of Business/Industry: Printing Industry
17. Father's Name (First, Middle, Last): Earl Allen
18. Mother's Name (First, Middle, Maiden Surname): Josie Duff
19e. Informant's Name/Relationship (Type, Print): Mrs.E.Evonne Allen (WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1401 Alexis Drive Joppa,MD.21085
20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hill Cemetery
Date: 12/20/99
20c. Location - City or Town, State: Baltimore,MD.
21. Signature of Funeral Service Licensee: E. F. Lassahn
22. Name and Address of Facility: E.F.Lassahn Funeral Home 11750 Belair Road Kingsville,MD.21087

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one) — Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [✓] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: P12246
29d. Date signed (Month, Day, Year): December 18,1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): T. Matthews 22 South Green St, Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: Janice G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Aubra Allen

6x1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39871

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Ann Bunch

2. Date of Death: Month 12 Day 19 Year 1999

3. Time of Death: 3:50 P.M.

4a. Facility Name (If not institution, give street and number): Keswick Multi. Purpose Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 242-30-4395

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 09 01 1911

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedant

10a. State: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 939 E. 41 St. St.

10f. Zip Code: 21218

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic Housewife

16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Walter Smith

18. Mother's Name (First, Middle, Maiden Surname): Estella Perry

19a. Informant's Name/Relationship (Type, Print): Willie Bunch (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1315 Glendale Rd. Balto., MD. 21139

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Arbutus Mem. Park Cem.

Date: 12/23/99

20c. Location - City or Town, State: Arbutus Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Caple Funeral Service, 5502 Winner Ave. Balto., Md. 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on aech lina.

		Approximate Interval Between Onset and Death
Immediate Causa (Final disease or condition resulting in death) e.	CEREBROVASCULAR ACC. DUE WITH SEVERE SWALLOWING DISEASE	8 WEEKS
Dua to (or as e consequence of): b.	ATHEROSCLEROTIC CEREBROVASCULAR DISEASE	10 YRS
Sequentielly list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disaese or Injury that initiated events resulting in death) Lest: Dua to (or es a consequance of): c.		
Due to (or as e consequence of): d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

ACUTE AND CHRONIC RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to complation of cause of death? 1☐ Yes 2☒ No

25. Was case raferred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Tima of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how Injury occurred

28e. Date of Injury (Month, Dey Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, daeth occurred at the tima, date end place, and due to tha ceuse(s) and mannar as stated. 2☐ Medical Examiner: On the besis of examination end/or invastigation, in my opinion, daath occurred at tha tima, data and place, and due to tha cause(s) and manner steted.

29b. Signature end title of certifier: [signature] MD

29c. License number: D 12399

29d. Date signed (Month, Day, Year): DECEMBER 20, 1999

30. Neme end addrass of person who completed cause of death (Item 23a) (Type, Print): CHARLES O. DOSWAN JR, MD KESWICK 700 W. 40TH ST. BALTIMORE, MD 21211

State Registrar

31. Data filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39872

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Michael Beaver
2. Date of Death (Month, Day, Year): DEC 18, 1999
3. Time of Death: 4:15am
4a. Facility Name (If not institution, give street and number): FutureCare Chesapeake
4b. City, Town, or Location of Death: Arnold
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 213-72-1171
6. Sex: 1 ☒ M 2 ☐ F
7. Age (in yrs. last birthday): 43 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV 20, 1956
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Arnold
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10a. Street and Number: 305 College Pkwy
10f. Zip Code: 21012
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Disabled
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): Lloyd Glenn Beaver
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Rector

19a. Informant's Name/Relationship (Type, Print): William David Beaver/brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 111 4th Avenue Baltimore, MD 21225

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.
Date: 12/18/99
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald
22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Sepsis	4 weeks
Due to (or as a consequence of): b.	Infected Decubitus ulcer	6 Months
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Quadriplegia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Wlymae MD Attending Doctor
29c. License number: D21684
29d. Date signed (Month, Day, Year): 12-18-1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C.V. CYRIAC M.D 8109 RITCHIE HWY, PASADENA, MD 21122

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: Jenna G Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39873

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LAWSON B. BROOKS

2. Date of Death: Month December Day 19 Year 1999

3. Time of Death: 10:30pm

4a. Facility Name (If not institution, give street and number): Mariner Health of North Arundel

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 220.03.6393

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 9/24/1914

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐ Yes 2☒ No XX

10e. Street and Number: 308 W. Furnace Branch Road

10f. Zip Code: 21060

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? ☒ Yes 2☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assembler

16b. Kind of Business/Industry: General Motors

17. Father's Name (First, Middle, Last): George L. Brooks

18. Mother's Name (First, Middle, Maiden Surname): Olive Whittaker

19a. Informant's Name/Relationship (Type, Print): WILLIAM L. BROOKS - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 478 Manchester, Maryland 21102

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MD. Veteran Cem.

Date: 12/22

20c. Location - City or Town, State: Crownsville, MD

21. Signature of Funeral Service Licensee: Kelly Gregory Fink

KELLY GREGORY FINK

22. Name and Address of Facility: FINK FUNERAL HOME, PA
426 Crain Hwy., SW, Glen Burnie, MD 21061

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hypertension with Peripheral Vascular Disease — 20yrs.

Due to (or as a consequence of):

b. Aortic Aneurysm — 3yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Ischaemic Heart Disease — 3yrs

Due to (or as a consequence of):

d. Renal failure

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Bilateral Decubitus ulcer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D14136

29d. Date signed (Month, Day, Year): 12/20/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D. SAWHNEY Suite 201 Crain Towers Glen Burnie md 21061

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: Renewed G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39871

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Patricia Beczkowski

2. Date of Death: Month December Day 20 Year 1999

3. Time of Death: 10:08pm

4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 217-34-5080

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 62 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): Oct. 11, 1937

9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 402 Drew St.

10f. Zip Code: 21224

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 yrs. College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Senior Center Balto. City

17. Father's Name (First, Middle, Last): Frank Przybylski

18. Mother's Name (First, Middle, Maiden Surname): Antoinette Przybylski

19a. Informant's Name/Relationship (Type, Print): Robert Beczkowski husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 402 Drew St. Balto. Md. 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Stanislaus Cem.

Date: Dec. 23 1999

20c. Location - City or Town, State: Dundalk

21. Signature of Funeral Service Licensee: John E. Connelly

22. Name and Address of Facility: Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Aortic Stenosis — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Ischemic Heart Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sam Ejadi M.D.

29c. License number: RES 000

29d. Date signed (Month, Day, Year): December 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Samuel Ejadi, M.D., Johns Hopkins Bayview Medical Center

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39875

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DORIS G BROWN
2. Date of Death: Month Dec. Day 19 Year 1999
3. Time of Death: 10:37 Am
4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL OF BALTIMORE
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death:

Funeral Director

5. Social Security Number: 217-20-6854
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 04 06 14
9. Birthplace (State or Foreign Country): S.C.

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 4212 Crawford Ave
10f. Zip Code: 21215
10g. Citizen of What Country? U.S.A.
11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th grade | College (1-4 or 5+): na
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: Brilliant Cleaners
17. Father's Name (First, Middle, Last): Arthur Mack
18. Mother's Name (First, Middle, Maiden Surname): Camilla Williams
19a. Informant's Name/Relationship (Type, Print): Gloria B. Jones
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4212 Crawford Ave, Baltimore Md 21215
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Crownsville Vet | Date: 12/22/99
20c. Location - City or Town, State: Crownsville, Md
21. Signature of Funeral Service Licensee: Dale March
22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Arterio sclerotic Heart disease.	several years.
Due to (or as a consequence of): b.	Dementia.	several year
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Tariq Khan.
29c. License number: D21730
29d. Data signed (Month, Day, Year): Dec 19 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TARIQ KHAN. SINAI HOSPITAL

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: D. Sparks.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39876

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Laura Ann Bruce

2. Date of Death: Month December Day 15 Year 1999

3. Time of Death: 9:00 A.M.

4a. Facility Name (If not institution, give street and number): 1411 Mirable Way

4b. City, Town, or Location of Death: Pasadena

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 217-62-9977

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 45 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 14, 1954

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1411 Mirable Way

10f. Zip Code: 21122

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates: 1974-77

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Social Worker

16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): John Bruce

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Field

19a. Informant's Name/Relationship (Type, Print): Elmer Bruce (Uncle)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1444 Hull Street Baltimore, Maryland 21230

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Md. Veterans Cemetery

Date: 12/17/99

20c. Location - City or Town, State: Crownsville, Md.

21. Signature of Funeral Service Licensee: John F Collins

22. Name and Address of Facility: McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acute Respiratory Failure

Due to (or as a consequence of): b. Multiple Sclerosis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William P Jones MD Deputy

29c. License number: D 060054

29d. Date signed (Month, Day, Year): 12/16/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): William P. Jones, MD 695 America 21035

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: Penny D Spates

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39877

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marion A. Baginski
2. Date of Death: Month December Day 20 Year 1999
3. Time of Death: 320PM
4a. Facility Name (If not institution, give street and number): 140 S. Bouldin Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 187-12-4892
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3-29-1924
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 140 S. Bouldin Street
10f. Zip Code: 21224
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: Korean Conflict
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Painter
16b. Kind of Business/Industry: Calvert Distillery

17. Father's Name (First, Middle, Last): Isadore Baginski
18. Mother's Name (First, Middle, Maiden Surname): Leona Unknown

19a. Informant's Name/Relationship (Type, Print): wife Josephine Baginski
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 140 S. Bouldin St., Baltimore, Maryland 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Redeemer | Date: 12/23/99
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Maria D. Zannino
22. Name and Address of Facility: Joseph N. Zannino Jr. Funeral Home 263 S. Conkling Street, Baltimore, Maryland 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis — 48°

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Renal Failure
Pressure Ulcer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Gwen W. Oldenquist MD
29c. License number: P63636
29d. Date signed (Month, Day, Year): 12-21-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gwen Oldenquist MD 5505 Hopkins Bayview Cir Baltimore MD 21224

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: ▶ G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

99-7604-510
ALBERT L. BULLOCK JR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ASP AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G781 3-2-2000 WR.

Certificate of Death

Reg. No. 99 39878

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Albert Lewis Bullock, Jr.
2. Date of Death Month Day Year: DECEMBER 17 1999
3. Time of Death: 2300
4a. Facility Name *(If not institution, give street and number)*: 1704 N. PORT ST.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 213-48-8726
6. Sex: 1☐ M 2☐ F — X
7. Age *(In yrs. last birthday)*: 42 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 29 1957
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Timonium
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2131 Fountain Hill Dr.
10f. Zip Code: 21093
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9; College (1-4or 5+): n/a
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mechanic
16b. Kind of Business/Industry: Motorcycles

17. Father's Name *(First, Middle, Last)*: Albert Lewis Bullock, Sr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Jeanette Lillian Guarino

19a. Informant's Name/Relationship *(Type, Print)*: Jeanette L. Bullock/Mother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2131 Fountain Hill Dr., Timonium, MD 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dulaney Valley Memorial Gardens — Date: 12/21/99
20c. Location - City or Town, State: Timonium, MD 21093

21. Signature of Funeral Service Licensee: Bryan W. Clary
22. Name and Address of Facility: Lemmon Funeral Home, 10 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. NARCOTIC AND ALCOHOL INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* SCENE

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☒ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*: 12-17-99
28b. Time of Injury: UNKNOWN M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: UNKNOWN
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: HOUSE
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 1704 N. PORT ST, BALTIMORE, MD

29a. Certifier *(check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to tha cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha time, dale end place, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier: Aaron Lockett MD
29c. License number: O.C.M.E
29d. Dale signed *(Month, Day, Year)*: DECEMBER 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Aaron Lockett, MD — 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dele filed *(Month, Day, Year)*: DEC 21 1999
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Bentley, Lewis W. December 15, 1999 4pm

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#5 PER F.H. G779 1-15-2000 J.A.

Certificate of Death

Reg. No. 99 39879

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LEWIS WILLIAM BENTLEY
2. Date of Death: Month DEC. Day 15 Year 1999
3. Time of Death: 4 50PM
4a. Facility Name (If not institution, give street and number): GILCREST NURSING CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: ~~211-22-5889~~ 212-12-5889
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 80 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 1, 1919
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: Maryland
10b. County: BALTIMORE
10c. City, Town or Location: LUTHERVILLE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1424 SCHOOL LANE
10f. Zip Code: 21093
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th grade; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TRUCK DRIVER
16b. Kind of Business/Industry: GENERAL TRASH REMOVAL

17. Father's Name (First, Middle, Last): LUTHER BENTLEY
18. Mother's Name (First, Middle, Maiden Surname): FRANCES CHATMAN

19a. Informant's Name/Relationship (Type, Print): GLADYS BENTLEY/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1424 SCHOOL LANE LUTHERVILLE, MD 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): DULANEY VALLEY MEMORIAL GARDEN
Date: 12-21-99
20c. Location - City or Town, State: TIMONIUM, MARYLAND
21. Signature of Funeral Service Licensee: Gary Harris
22. Name and Address of Facility: CHATMAN-HARRIS
5240 REISTERSTOWN ROAD
BALTIMORE, MARYLAND 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CHOLANGIOCARCINOMA — 2 months
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W. Anthony Riley, MD
29c. Licensa number: D25205
29d. Data signed (Month, Day, Year): December 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W.A. Riley GBMC 6701 N. Charles St. Balto. MD 21204

State Registrar

31. Data filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: G Sparks

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

To be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

A7 351

DHMH 16 Rev 6/95

ADH
EARL LEE BAILEY
99-7614-510
amend item 23a,27,28a,b,c,d,e,f per me G781
3/10/00 yg

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39880

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EARLE LEE BAILEY
2. Date of Death (Month, Day, Year): DECEMBER 18, 1999
3. Time of Death: 2310 PM.
4a. Facility Name (If not institution, give street and number): 1516 N. SPRING STREET
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 230-13-6947
6. Sex: X 1☐ M 2☐ F
7. Age (In yrs. last birthday): 39 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): SEPT. 5,1960
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1516 N. SPRING STREET
10f. Zip Code: 21213
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: AFRO-AMERICAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2YEARS
16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired): PACKER /PIZZ FACTORY
16b. Kind of Business/Industry: "JOE CURBY"

17. Father's Name (First, Middle, Last): LOUIS BAILEY
18. Mother's Neme (First, Middle, Maiden Surname): ALMA WORD

19e. Informant's Neme/Relationship (Type, Print): ALMA JEFFERSON/ mother
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1516 N. SPRING STREET BALTIMORE, MD.21213

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): MT. ZION CEMETERY
Dete: DEC.28,1999
20c. Location - City or Town, Stete: BALTIMORE,MD.

21. Signature of Funeral Service Licensee: Bernadine V. Scruggs
22. Name end Address of Feciility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTO,MD. 21213

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on aach line. | Approximate Interval Between Onset and Death

Immediete Causa (Final diseasa or condition resulting in death)
a. NARCOTIC INTOXICATION
Due to (or es e consequence of):
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
b.
Due to (or as e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Wes cese referred to medicat examiner? ☒ Yes 2☐ No
26. Placa of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined
28a. Date of Injury (Month, Day Year): 12/18/99
28b. Time of Injury: unknown M
28c. Injury et Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: unknown
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify): home
28f. Location (Street end Number or Rural Route Number, City or Town, State): Baltimore, MD. 1516 N. Spring St.

29a. Cartifier (Check only one): 1☐ Certifying Physician: To tha best of my knowledga, death occurred at the time, date and place, and dua to tha cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred et tha tima, data and place, end due to tha cause(s) and menner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: OCME
29d. Date signed (Month, Day, Year): DECEMBER 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JASON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: Jennie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39881

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BERTHA BYRNES.
2. Date of Death: Month DECEMBER Day 19TH Year 1999
3. Time of Death: 11:45 AM
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 212-09-6895
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 29, 1916
9. Birthplace (State or Foreign Country): MD

Usual Residance of Decedent

10a. Steta: MD
10b. County: Baltimore
10c. City, Town or Location: Randallstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9124 Liberty Road
10f. Zip Code: 21133
10g. Citizen of What Country?: USA

11. Merital Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elemantary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner
16b. Kind of Business/Industry: Grocery Store

17. Father's Nema (First, Middle, Last): John Wosk
18. Mother's Name (First, Middle, Maiden Surname): Mary Unknown

19a. Inlorment's Name/Ralationship (Type, Print): Jim Byrnes Son
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7310 Penrith Drive, Mechnicsville, VA 23116

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other place): Lakeview Memorial Park
Data: 12/22/99
20c. Location - City or Town, Stete: Sykesville, MD

21. Signature of Funeral Service Licensee: John A. Shaw
22. Name and Address of Facility: Eline Funeral Home 11824 Reisterstown Rd. Reisterstown, MD 21136

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not entar the mode of dying, such es cardiac or respiratory errest, shock or haart failure. List only ona causa on each line.

Approximete Intarvat Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)
e. INTRACRANIAL HEMORRHAGE. — 3 DAYS
Due to (or as e consequence of):
b. CEREBRO VASCULAR DISEASE. — 3 YEARS.

Sequentielly iist conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last
Due to (or as e consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

ISCHEMIC LEFT LEG.
THROMBOLYSIS OF CLOT.
CORONARY ARTERY DISEASE.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy lindings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined
28a. Deta of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, larm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifiar (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the tima, date and place, end due to the cause(s) and manner es stated.
2☐ **Medicat Examiner:** On the basis of axamination and/or investigation, in my opinion, death occurred et tha time, date and place, and due to the cause(s) and mennar stated.

29b. Signature end title of certifier: Harish
29c. License number: D42723.
29d. Date signed (Month, Day, Year): DECEMBER 19TH 1999

30. Neme end address ol person who completed cause of death (Item 23a) (Type, Print): AVVERAHALLI M HARISH. NORTHWEST HOSPITAL CENTER. 5401 OLDCOURT RD MD 21133.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Dete liled (Month, Day, Yeer): DEC 21 1999
32. Registrar's Signeture: D Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM #18 PER FH G778 12/21/99 AH

Certificate of Death

Reg. No. 99 39882

Physician /Medical Examiner

1. Decedent's Nama (First, Middle, Last): Lester L. Baublitz Sr.

2. Date of Death (Month, Dey, Yaar): 12-18-1999

3. Tima of Death: 1:35a

4a. Facility Nama (If not institution, give street end number): Gilchrist Center for Hospice Care

4b. City, Town, or Location of Daath: Towson

4c. County of Daath: Baltimore

Funeral Director

5. Social Sacurity Numbar: 214-24-9890

6. Sax: 1 [X] M 2 [ ] F

7. Aga (In yrs. last birthday): 72 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Dey, Yaar): 1/25/1927

9. Birthplaca (State or Foreign Country): MD

Usual Residance of Decedant

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Reisterstown

10d. Insida City Limits: 1 [ ] Yes 2 [X] No

10e. Straat and Numbar: 316 Academy Avenue

10f. Zip Code: 21136

10g. Citizen of Whet Country?: USA

11. Marital Status: 1 [ ] Navar Marriad 2 [X] Marriad 3 [ ] Widowed 4 [ ] Divorced

12. Was Dacedant Evar in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No If Yas, Giva Yaar or Datas:

13. Was Decadant of Hispanic Origin? (Spacify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:

14. Raca - Amarican Indian, Black, Whita, atc. Specify: white

15. Dacedant's Education (Specify only highest grade completed): Elamantary/Secondary (0-12): 7; Collaga (1-4or 5+):

16a. Dacedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Groundsman/ Maintainence

16b. Kind of Businass/Industry: Mc Donogh School

17. Fathar's Name (First, Middle, Last): Howard Baublitz

18. Mother's Nama (First, Middle, Maiden Sumame): ALICE BOSLEY

19a. Informant's Name/Ralationship (Type, Print): Mrs. Marjorie M. Baublitz (Wife)

19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code): 326 Academy Ave. Reisterstown, Md. 21136

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Ramoval from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Carroll Cremation Service

Data: 12/20/99

20c. Location - City or Town, State: Hampstead, Md.

21. Signature of Funaral Service Licansaa: Sam B Eline

22. Name end Addrass of Facility: ELINE FUNERAL HOME 11824 Reisterstown Road Reisterstown, Md. 21136

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha daath. Do not antar tha moda of dying, such es cardiac or raspiretory errast, shock, or heart failura. List only one causa on each line.

Approximata Intervel Between Onsat and Daath

Immediate Cause (Final disease or condition resulting in death): a. renal CARCINOMA — 1 month

Dua to (or as a consequence of): b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consaquance of): c.

Dua to (or as a consaquence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa givan in Part I.: renal failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yas 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was en autopsy performad? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings availabla prior to completion of causa of death? 1 [ ] Yas 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yas 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA; Othar: 4 [ ] Nursing Home 5 [ ] Rasidance 6 [X] Othar (Specify) Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28b. Tima of Injury

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurrad

28e. Date of Injury (Month, Day Yaar)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledga, deeth occurred at the time, dete end piece, end dua to tha causa(s) and menner as steted. 2 [ ] **Medical Examiner:** On tha basis of axemination and/or invastigation, in my opinion, daath occurred at tha time, data and place, and dua to tha causa(s) and mannar stated.

29b. Signatura and title of Certifier: W. Thomas Riley MD

29c. Licansa number: D25205

29d. Date signed (Month, Dey, Yaar): December 18, 1999

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): W.A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

State Registrar

31. Data filad (Month, Dey, Yaar): DEC 21 1999

32. Registrar's Signatura: Penny P Sparks

DHMH 16 Rev 6/95

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

December 18, 1999 0135

Lester Baublitz

10

AH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39883

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH ALFRED BRESNICK

2. Date of Death: Month 12 Day 17 Year 99

3. Time of Death: 11:15 a.m.

4a. Facility Name (If not institution, give street and number): 940 S. LAKEWOOD AVENUE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-28-2091

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): FEB. 18, 1934

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD. | 10b. County: N/A | 10c. City, Town or Location: BALTIMORE | 10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 940 S. LAKEWOOD AVENUE | 10f. Zip Code: 21224 | 10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1952

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MACHINE OPERATOR

16b. Kind of Business/Industry: AMERICAN CAN CO.

17. Father's Name (First, Middle, Last): JOSEPH ALBERT BRESNICK

18. Mother's Name (First, Middle, Maiden Surname): FLORENCE WILHELMINA SCHMIDT

19a. Informant's Name/Relationship (Type, Print): HERMAN BRESNICK/ BROTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3318 ELMORA AVENUE, BALTIMORE, MD. 21213

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): CEDAR HILL CEMETERY | Date: 12/20/99

20c. Location - City or Town, State: GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: KILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTIMORE, MD. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Myocardial Infarction	1hr
Due to (or as a consequence of): b.	Cardiovascular Disease	Yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	Hypertension	
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Severe Chronic Arthritis Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D4216

29d. Date signed (Month, Day, Year): 12-12-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Simon Scalia 2801 Hudson St. Balto, Md. 21224

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39884

Boellner, Beatrice
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Beatrice Jeannette Boellner
2. Date of Death (Month, Day, Year): December 19 1999
3. Time of Death: 3:20 PM
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-22-6798
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 70 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb.4 1929
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD.
10b. County: Baltimore
10c. City, Town or Location: Timonium
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8 Mullingar Ct. #202
10f. Zip Code: 21093
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookkeeper
16b. Kind of Business/Industry: Property Development

17. Father's Name (First, Middle, Last): William Adolph
18. Mother's Name (First, Middle, Maiden Surname): Gladys Keen

19a. Informant's Name/Relationship (Type, Print): Mrs. Jeanne Conner/ Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 218 Woodbine Ct. Forest Hill, MD. 21050

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Gdns.
Date: 12-23-99
20c. Location - City or Town, State: Timonium, MD.

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc 1050 York Rd. Towson, MD. 21204

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — 1 Week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
cerebro vascular Accident
cardiomyopathy

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ S. Ragueesp
29c. License number: D 53720
29d. Date signed (Month, Day, Year): 12/20/99.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sinnarajah Ragurajah, MD 9000 Franklin Square Drive Baltimore, MD 21237

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: [signature]

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#1 perPhyG779 1/7/2000 EW

Certificate of Death

Reg. No. 99 39885

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANDREA ~~Lee~~ Lee BRUBAKER

2. Date of Death: Month Dec. Day 13 Year 1999

3. Time of Death: 0528

4a. Facility Name (If not institution, give street and number): University of Maryland Medical System

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 207 30 6558

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 59 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 23, 1940

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: PA

10b. County: York

10c. City, Town or Location: Penn Twp.

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 36 Pinewood Circle

10f. Zip Code: 17331

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Woodrow Noggle

18. Mother's Name (First, Middle, Maiden Surname): Bernadine Naomi Bollinger

19a. Informant's Name/Relationship (Type, Print): Richard K. Brubaker husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 36 Pinewood Circle Hanover Pa 17331

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt Olivet Cem.

Date: 12/17/99

20c. Location - City or Town, State: Hanover PA

21. Signature of Funeral Service Licensee: Joseph V. Yingling

22. Name and Address of Facility: Wetzel Funeral Home 349 Carlisle St Hanover Pa 17331

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Liver Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Non Alcoholic Steatohepatitis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: MD

29c. License number: 12436

29d. Data signed (Month, Day, Year): 12/14/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ERIC SHAW 22 South Greene St. Balto, MD 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: B Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39886

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GRACE ELIZABETH BROWN
2. Date of Death: Month DECEMBER Day 20 Year 1999
3. Time of Death: 12:35 AM
4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-22-5703
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-28-25
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 3105 ROYSTON AVE
10f. Zip Code: 21214
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9TH; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): RAYMOND STEPHEN TULL
18. Mother's Name (First, Middle, Maiden Surname): AIRY SELLER

19a. Informant's Name/Relationship (Type, Print): EARL E. BROWN SR.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3105 ROYSTON AVE BALTIMORE MD 21214

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): PARKWOOD CEMETERY
Date: 12-22-99
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Robert E. Altenburg Lic D00002
22. Name and Address of Facility: ALTENBURG FUNERAL HOME, P.A. 6009 HARFORD ROAD BALTO, MD 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. MYOCARDIAL INFARCTION	2 DAYS
Due to (or as a consequence of):	b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DIABETES MELLITUS
CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D15135
29d. Date signed (Month, Day, Year): DECEMBER 20 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PENELOPE P. SCOTT MD 5601 LOCHMERE BLVD BALTIMORE, MD 21239

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39887

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
IDA		BRESSNER	DEC. 17 1999	11:47PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
FUTURE CARE-CANTON HARBOR	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-14-1141	1☐ M 2☒ F	100 Yrs.			12/24/1898	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
22 N. CLINTON STREET	21224	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yas, Giva Year or Datas:	1☐ Yas 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		SECRETARY	BANKING

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
HYMAN BRESSNER	SARAH BERMAN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
ISABEL A. CONLEY-WATERS/FRIEND	11 JUNEWAY LANE BERLIN, MD. 21811

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	HEBREW ORTHODOX MEMORIAL SOCIETY	12/19/99	DUNDALK, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Jay Allan Lewis	SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD. 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line.

		Approximata Interval Between Onset end Death
Immediata Causa (Final disease or condition resulting in death) a.	Arteriosclerotic Heart Disease	75 years
Due to (or as a consequence of): b.	Arteriosclerosis	75 years
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en autopsy performed?	24b. Wara autopsy findings available prior to completion of cause of death?
1☐ Yas 2☒ No	1☐ Yes 2☐ No

25. Wes cesa referred to medicat examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be detarmined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To tha best of my knowledge, death occurred at the tima, data and place, and dua to tha causa(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and piece, and dua to the cause(s) and manner stated.

29b. Signature and title of Certifier	29c. License number	29d. Dete signed (Month, Day, Year)
▶ [signature]	D11150	12/18/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MELITO M. TORRES, MD 441 S. ELLWOOD AVE, BALTO, MD 21224

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 21 1999	▶ Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39888

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jean Walker Colvin

2. Date of Death (Month, Day, Year): DECEMBER 21, 1999

3. Time of Death: 7:55 AM

4a. Facility Name (If not institution, give street and number): Stella Maris @ Mercy Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-05-2995

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JUNE 29, 1911

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1904 Ramblewood Road

10f. Zip Code: 21239

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk

16b. Kind of Business/Industry: Paint Manufacturer

17. Father's Name (First, Middle, Last): Harry L. Walker

18. Mother's Name (First, Middle, Maiden Surname): Anna Unk.

19a. Informant's Name/Relationship (Type, Print): Frank D. Colvin/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1904 Ramblewood Rd. Baltimore, MD 21239

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc. Date: 12/21/99

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik

Edward A. Gregorchik

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Adenocystic carcenoma of sinus

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Macular Degeneration

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): STELLA MARIS AT MERCY

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Edward A. Gregorchik MD

29c. License number: D 40854

29d. Date signed (Month, Day, Year): DECEMBER 21, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DAVID RISEBERG 301 St Paul Pl BALTIMORE MD 21202

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CJ

Patricia Ann Cornwell
99-7595-047

AMEND ITEMS: #23 PART I, 27 PER MEO G778 12-30-99 WR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39889

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Patricia Ann Cornwell

2. Date of Death: Month December Day 17 Year 1999

3. Time of Death: 02:30 AM.

4a. Facility Name (If not institution, give street and number): Seagull Trailer Park / Lot 121

4b. City, Town, or Location of Death: Ocean City

4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 217-46-6896

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 46 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAR 23, 1953

9. Birthplace (State or Foreign Country): District of Columbia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Worcester

10c. City, Town or Location: Ocean City

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: Seagull Trailor Park/Lot 121

10f. Zip Code: 21842

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accounting

16b. Kind of Business/Industry: Storage Business

17. Father's Name (First, Middle, Last): Delyn Alumbaugh

18. Mother's Name (First, Middle, Maiden Surname): Ann Marie Hisle

19a. Informent's Name/Relationship (Type, Print): Ann Marie Kain/mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 819 Brice Road Rockville, MD 20852

20a. Method of Disposition: 1☐ Buriat 2☒ Cremation 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piece): Metro Crematory, Inc. Date: 12/20/99

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errast, shock, or heart teilure. List only one cause on eech line. Approximete Interval Between Onset end Deeth

Immediate Cause (Finet disease or condition resulting in death): a. FATTY LIVER

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicat examiner? 1☒ Yes 2☐ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, tectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner es stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner steted.

29b. Signature and title of certifier: Marjorie McGrath

29c. License number: O.C.M.E.

29d. Dete signed (Month, Day, Year): December 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARJORIE A. KOROL MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39890

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HELENE K. CLAYTON

2. Date of Death: Month December Day 17 Year 1999

3. Time of Death: 2:14 P.m

4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 212-74-9843

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 96 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT. 19, 1903

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 201 CEDAR PLACE

10f. Zip Code: 21060

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): JOHN SMITH

18. Mother's Name (First, Middle, Maiden Surname): LAURA SILS

19a. Informant's Name/Relationship (Type, Print): JUNE HERREN/GRANDDAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1803 TOWER RD. GLEN BURNIE, MD 21060

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): GLEN HAVEN MEM. PK. Date DEC. 21, 1999

20c. Location - City or Town, State: GLEN BURNIE, MD

21. Signature of Funeral Service Licensee: Helene Clayton

22. Name and Address of Facility: KIRKLEY-RUDDICK FUNERAL HOME P.A. 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061

To Be Completed by Funeral Director

Helene Clayton

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MULTIPLE ORGAN FAILURE

Due to (or as a consequence of):
b. SEPTICEMIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: MD.

29c. License number: D43977

29d. Date signed (Month, Day, Year): December 17 1999

30. Neme and address of parson who completed cause of death (Item 23a) (Type, Print): Awoken Okeyuno. 301 Hospital Drive, Glen Burnie. MD. 21061

State Registrar

31. Date filed (Month, Dey, Year): DEC 21 1999

32. Registrar's Signeture: Geneva G Sparks

To the Hospital or Attending Physician: The law requiras that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

99-7617-003

B.K.S

MICHAEL THOMAS COLLINS

AMEND ITMS: #23 PART I, 27 PER MEO G779 1-5-2000 WR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39891

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MICHAEL THOMAS COLLINS SR.

2. Date of Death (Month, Day, Year): DEC. 19, 1999

3. Time of Death: 0533 AM

4a. Facility Name (If not institution, give street and number): 209 NORTH CAROLINA AVENUE

4b. City, Town, or Location of Death: PASADENA

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 217-86-3784

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 38 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 07 1961

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Anne Arundel Co.

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 209 North Carolina Ave.

10f. Zip Code: 21222

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Warehouse Man

16b. Kind of Business/Industry: Food

17. Father's Name (First, Middle, Last): Milton Polaski

18. Mother's Name (First, Middle, Maiden Surname): Louise Ann Ratliff

19a. Informant's Name/Relationship (Type, Print): Michael Thomas Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 152 Springwood Drive, New Freedom, Pa. 17349

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place) / Date: Green Mount Cemetery 12/23/99

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Daniel A. Mayo

22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. HYPERTENSIVE CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jan Locke MD

29c. License number: O.C.M.E

29d. Date signed (Month, Day, Year): DEC. 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Jan Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: Jeanne B. Spurlock

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39892

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Walter Carrollton Crispens
2. Date of Death (Month, Day, Year): December 18, 1999
3. Time of Death: 6:45 pm
4a. Facility Name (If not institution, give street and number): 213 Larkspur Lane
4b. City, Town, or Location of Death: Middle River
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217 34 9680
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 62 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 27, 1937
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Middle River
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 213 Larkspur Lane
10f. Zip Code: 21220
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Meat Cutter
16b. Kind of Business/Industry: Grocery Store

17. Father's Name (First, Middle, Last): Walter C. Crispens Sr.
18. Mother's Name (First, Middle, Maiden Surname): Eleanora Giddy

19a. Informent's Name/Relationship (Type, Print): Carol Crispens (Wife)
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 213 Larkspur Lane Baltimore, Md. 21220

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Pleca of Disposition (Neme of cemetery, cremetory or other place): Oak Lawn Cemetery — Date: 12/21/1999
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: John W. Burkowske
22. Name and Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on each line.

Approximete Intervel Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): e. Cancer Of Pancreas — 6 Months

Due to (or es a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Last:

b. Due to (or es e consequenca of):

c. Due to (or es e consequenca of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of exemination and/or Investigetion, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: DO 2022
29d. Date signed (Month, Day, Yeer): 12-20-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Leopoldo Cruss M.D. 405 Stemmers Run Rd. Balto., Md. 21221

State Registrar

31. Date filed (Month, Dey, Year): DEC 21 1999
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Division of Vital Records, P.O. Box 68760,

MDLATZ

15

AH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39893

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DOUGLAS CAMPBELL
2. Date of Death (Month, Day, Year): December 18, 1999
3. Time of Death: 01:37A
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death:

Funeral Director

5. Social Security Number: 218-13-3633
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 16 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 26, 1983
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 800 North Marlyn Avenue
10f. Zip Code: 21221
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: School

17. Father's Name (First, Middle, Last): Patrick Campbell
18. Mother's Name (First, Middle, Maiden Surname): Cathie Getz

19a. Informant's Name/Relationship (Type, Print): Patrick Campbell (father)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 800 North Marlyn Avenue, Essex, Maryland 21221

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Crematory
Date: 12/22/99
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. HYPOTENSIVE SHOCK	12 HOURS
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. DIABETIC KETOACIDOSIS	2 DAYS
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D0053215
29d. Date signed (Month, Day, Year): DECEMBER 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WYNNE MORRISON, PICU, 600 N. WOLFE, BALTIMORE MD 21287

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: Lenora G Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39894

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen M. Crabbe

2. Date of Death (Month, Day, Year): December 18, 1999

3. Time of Death: 9.00 PM.

4a. Facility Name (If not institution, give street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 220-18-4468

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 28, 1924

9. Birthplace (State or Foreign Country): VA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Anne-Arundel

10c. City, Town or Location: Pasadena Maryland

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8650 Machias Harbour

10f. Zip Code: 21122

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Millard Kirk Hanks

18. Mother's Name (First, Middle, Maiden Surname): Mary Lucille Luckham

19a. Interment's Name/Relationship (Type, Print): Connie Fay Gurley / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8650 Machias Harbour, Pasadena Maryland 21122

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Farnham Baptist Church Cemetery

Date: Dec. 21, 1999

20c. Location - City or Town, State: Farnham, VA

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.

22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE 2° to PNEUMONIA

Due to (or as a consequence of):

b. CAD, CHF

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. CRF

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D51245

29d. Date signed (Month, Day, Year): December 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAJID SHARIF NORTH ARUNDEL HISPITAL MD.

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Crabbe, Helen M

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than 'natural', or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

Art

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39895

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT R DIETZ
2. Date of Death: Month DEC Day 17 Year 1999
3. Time of Death: 10:45 Am
4a. Facility Name (If not institution, give street and number): Carroll County General Hospital
4b. City, Town, or Location of Death: Westminister
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 212-32-8929
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 63 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 21 1936
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Finksburg
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2665 Secretariat Drive
10f. Zip Code: 21048
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Welder
16b. Kind of Business/Industry: 3Star Iron Company

17. Father's Name (First, Middle, Last): John James Dietz
18. Mother's Name (First, Middle, Maiden Surname): HAttie Geyer

19a. Informant's Name/Relationship (Type, Print): Ramona J. Dietz / wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2665 Secretariat Drive Finksburg MD 21048

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetary, cremetory or other place): Moreland Memorial Date: 12/22/99
20c. Location - City or Town, State: Baltimore MD.

21. Signature of Funeral Service Licensee: R Terry Connelly
22. Name and Address of Facility: Connelly Funeral Home of Essex 300 Mace AVe. Baltimore Md. 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hypoxemia — 2 days

Due to (or as a consequence of): b. End Stage Chronic Respiratory Failure (obstructive type) — 17 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease

atrial fibrillation

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yas 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Lisa Kim, M.D
29c. License number: D52479
29d. Date signed (Month, Day, Year): December 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LISA KIM, M.D. at Carroll County General Hospital at 200 Memorial Avenue, Westminster, MD 21157

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39896

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LILY MAY DADE
2. Date of Death: Month December Day 15 Year 1999
3. Time of Death: 6:05 p.m.
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-12-3205
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 98 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): DEC. 10, 1901
9. Birthplace (State or Foreign Country): MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND
10b. County:
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 4800 SETON DRIVE
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE
16b. Kind of Business/Industry:
17. Father's Name (First, Middle, Last): JAMES Smith
18. Mother's Name (First, Middle, Maiden Surname): HENRIETTA STANLEY
19a. Informant's Name/Relationship (Type, Print): LOUIS DADE, JR.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 500 N. LOUDON AVE BALTO. MD 21229
20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS MEM. PK. Date: 12/20
20c. Location - City or Town, State: ARBUTUS, MD.
21. Signature of Funeral Service Licensee: ▶ Elona Adams Jones
22. Name and Address of Facility: MARSHALL W. JONES, JR. F.H., P.A. 4101 Edmondson Ave BALTO. MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Heart Disease — Several Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Dementia — Several Years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Tariq Khan
29c. License number: D21730
29d. Date signed (Month, Day, Year): December 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Tariq Khan, Sinai Hospital, 2401 W. Belvedere Ave., Baltimore, MD 21215

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Patient known as: Lily Dade

ORIGINAL

99-7543-510
crn
Beverly Eugenia Forrest

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39897

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Beverley E. Forrest
2. Date of Death: Month December Day 14 Year 1999
3. Time of Death: 9:02 A.M.
4a. Facility Name (If not institution, give street and number): 2644 Oswego Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-50-2553
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 52 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 27, 1947
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2644 Oswego Ave.
10f. Zip Code: 21215
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Afro-American

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse's Assistant
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Stanley Forrest
18. Mother's Name (First, Middle, Maiden Surname): Florence Savage

19a. Informant's Name/Relationship (Type, Print): Ms. Chevondelear Brooks (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 312 S. Spring Ct. Balto. Md. 21231

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial Park
Date: 12/21/99
20c. Location - City or Town, State: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hypertensive Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Laron Locke M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): December 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39898

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RAY DAVID FAWLEY

2. Date of Death (Month, Day, Year): DECEMBER 16 1999

3. Time of Death: 2:00 PM

4a. Facility Name *(If not institution, give street and number)*: 1306 SOUTH CHARLES STREET

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 232-22-7039

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 30 1916

9. Birthplace *(State or Foreign Country)*: W. Virg.

Usual Residence of Decedent

10a. State: Md.

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1306 S. Charles Street

10f. Zip Code: 21230

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Detas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 8 | College (1-4or 5+): 0

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Burner

16b. Kind of Business/Industry: General Ship Repair

17. Fethar's Neme *(First, Middle, Last)*: David L. Fawley

18. Mother's Neme *(First, Middle, Maiden Sumeme)*: Margaret Poling

19a. Informent's Neme/Relationship *(Type, Print)*: Betty L. Fawley (Wife)

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1306 S. Charles Street, Baltimore, Md. 21230

20a. Method of Dispoaition: 1 [X] Buriel 2 [ ] Cramation 3 [ ] Removal from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, cremetory or other pieca)*: Loudon Park Cemetery | Dete: 12/20/99

20c. Location - City or Town, Stete: Baltimore, Md.

21. Signature of Funerel Servica Licensee: David A Hayes

22. Name end Address of Fecility: McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediete Cause (Finel diseese or condition resulting in deeth): a. Acute Myocardial Infarction

Dua to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last:

b. Hypertension

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.: Chronic Obstructive Lung Disease

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings availeble prior to completion of cause of deeth? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Homa 5 [X] Residenca 6 [ ] Other *(Specify)*

27. Menner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner es stated. 2 [ ] **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end pleca, end due to the cause(s) and menner steted.

29b. Signature and title of certifier: A Sridhar M.D

29c. License number: D 50470

29d. Date signed *(Month, Dey, Year)*: 12/17/99

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): SRIDHAR ATLURI M.D 1319 Light Street. Baltimore MD 21230

State Registrar

31. Dete filed *(Month, Dey, Year)*: DEC 21 1999

32. Registrer's Signeture: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39899

Patient known as Ronald Fries

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ronald Bell Fries
2. Date of Death Month Dey Yaer: December 19, 1999
3. Time of Death: 1:06 pm
4e. Facility Name *(If not institution, give street end number)*: Sinai Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

Funeral Director

5. Social Security Number: 236-50-1159
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Yeer)*: Aug. 2, 1933
9. Birthplace *(Stete or Foreign Country)*: WV

Usuei Residence of Decedent

10e. State: MD
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street end Number: 1000 Dunholmes Rd
10f. Zip Code: 21136
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - Amarican Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mechanic
16b. Kind of Business/Industry: Vending Co.

17. Fether's Name *(First, Middle, Last)*: Arthur Fries
18. Mothar's Name *(First, Middle, Maiden Surneme)*: Anna Frances Winkler

19a. Informent's Neme/Relationship *(Type, Print)*: Beverly A. Fries Wife
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 1000 Dunholme Rd., Reisterstown, MD 21136

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Rest Haven Cemetery
Dete: 12/23/99
20c. Location - City or Town, Stete: Hagerstown, MD

21. Signature of Funeral Service Licensee: Mark Deskiewicz
22. Name end Address of Feciility: Eline Funeral Home 11824 Reisterstown Rd Reisterstown, MD 21136

Physician /Medical Examiner

23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrast, shock, or hend failure. List only one cause on each line.

Approximete Intervel Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in death): e. Dilated Cardiomyapathy
Due to (or es e consequence of):

Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Lest
b. Due to (or es e consequence of):
c. Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying cause given in Part I.
Ventricolar Tachycardia, Renal Faillure, Diabetes mellitis, Right below the Knee amputation, Hypertension

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveileble prior to completion of causa of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Piece of Deeth *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Sulcida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Date of Injury *(Month, Dey Yeer)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) end menner es steted.
2☐ **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier: Jena Crisler D.O.
29c. Licensa number: RES-000
29d. Date signed *(Month, Dey, Yeer)*: December 19, 1999

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Jena Crisler DO. Sinai Hospital, 2401 West Belvedere Baltimore Maryland 21215

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: DEC 21 1999
32. Registrer's Signeture: Jenna B Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. **Important: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours eftar death.
To the Funeral Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

AH

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39900

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DAVID JEROME FISH
2. Date of Death (Month, Day, Year): DECEMBER 14 1999
3. Time of Death: 7:19PM
4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-58-0265
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 49 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7-22-50
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 923 Walnut Grove Rd.
10f. Zip Code: 21221
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Systems Analyst
16b. Kind of Business/Industry: Federal Credit Union

17. Father's Name (First, Middle, Last): Jerome D. Fish
18. Mother's Name (First, Middle, Maiden Surname): Charlotte M. Wyczalek

19a. Informant's Name/Relationship (Type, Print): Charlotte Fish / mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 923 Walnut Grove Rd. Essex, MD 21221

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn
Date: 12-18-99
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Denise S. Kelly
22. Name and Address of Facility: Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 21237

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	LUNG CANCER	ONE YEAR
Due to (or as a consequence of): b.	SEPTICEMIA	TWO WEEKS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: RESIDENT
29c. License number: D0055481
29d. Date signed (Month, Day, Year): DECEMBER 14, 1999.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHWE MRA GYAW 3001 SOUTH HANOVER STREET BALTIMORE MD 21225

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39901

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NELIA GATLIN
2. Data of Death Month Day Year: DECEMBER 16, 1999
3. Time of Death: 12 07 PM
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 239-48-3148
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6-3-1915
9. Birthplace (State or Foreign Country): FI

Usual Residence of Decedent

10a. State: Md
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2450 Terra Firma Road
10f. Zip Code: 21225
10g. Citizen of What Country?: U.S.A
11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Amarican Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade | College (1-4or 5+): BA Degree
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): School Teacher
16b. Kind of Business/Industry: School
17. Father's Name (First, Middle, Last): Neil Clark
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Pearson
19a. Informent's Neme/Reletionship (Type, Print): Brenda Cook-Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 181 Ridge Chapel Road Hanover, Md 21076
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Mem Park
Date: 12-20-99
20c. Location - City or Town, State: Arbutus, Md
21. Signature of Funeral Service Licensee: John B. Johnson Jr.
22. Name and Address of Facility: March-F.H. West 4300 Wabash Avenue Balto, Md 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. | Approximata Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. INTRA CRANIAL HEMORRHAGE — 1 DAY

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION, DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end piece, and due to the ceuse(s) and manner steted.

29b. Signeture end title of certifier: C. Ravi MD
29c. License number: D37733
29d. Date signed (Month, Day, Year): DECEMBER 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C. RAVI MD, NHC, BALTO. MD 21133

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39902.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM F. GOEHRING, SR.

2. Date of Death: Month December Day 19 Year 1999

3. Time of Death: 1050

4a. Facility Name (If not institution, give street and number): Sinai Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 214-26-9361

6. Sex: 1☐ M 2☐ F — X

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 20 1928

9. Birthplace (State or Foreign Country): Germany

Usual Residence of Decedent

10a. State: Md.

10b. County: Anne Arundel Co.

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 855 Woods Road

10f. Zip Code: 21122

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Auto Mechanic

16b. Kind of Business/Industry: self-employed

17. Father's Name (First, Middle, Last): Willi Franz Goehring

18. Mother's Name (First, Middle, Maiden Surname): Elsa Margaret Lehe

19a. Informant's Name/Relationship (Type, Print): Linda Kellum (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1407 Saunders Way, Glen Burnie, Md. 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Memorial Park

Date: 12/22/99

20c. Location - City or Town, State: Glen Burnie, Md.

21. Signature of Funeral Service Licensee: David A. Hayes

22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)

a. Coronary artery Disease

Due to (or as a consequence of):

b. Left Ventricular failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last

Due to (or as a consequence of):

c. S/p Redo Coronary Artery Bypass

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☐ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case refarred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner steted.

29b. Signeture and title of certifier:

29c. License number: D0053607

29d. Date signed (Month, Day, Year): December 20, 1999

30. Neme and address of person who completed causa of death (Item 23a) (Type, Print): Paul Burns 2411 West Belvedere Avenue, Suite 502, Baltimore

State Registrar

31. Dete filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Ft. Lauren a: William Goehring

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once. William Goehring

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

99-7594-510
crn
Joel Graham

Transferred to Bailey-Kirk F. H. Princeton, W. Va.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39903

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joel Gregory Graham

2. Date of Death (Month, Day, Year): December 16, 1999

3. Time of Death: 5:41 P.M.

4a. Facility Name (If not institution, give street and number): University of Maryland Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 232-15-1999

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 32 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 1-15-67

9. Birthplace (State or Foreign Country): Columbus, Ohio

Usual Residence of Decedent

10a. State: Va.

10b. County:

10c. City, Town or Location: Winchester

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1112 Franklin Street, Apt. 2

10f. Zip Code: 22601

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction Worker

16b. Kind of Business/Industry: Contruction

17. Father's Name (First, Middle, Last): Dasil C. Graham

18. Mother's Name (First, Middle, Maiden Surname): Sarah Foley

19a. Informant's Name/Relationship (Type, Print): Sandra Graham

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1112 FranklinSt. Apt.2, WinchesterVa.

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Shrewsbury, | Date: 12/22/99

20c. Location - City or Town, State: Beeson, W. Va.

21. Signature of Funeral Service Licensee: Maria B. Zannino

22. Name and Address of Facility: Joseph N. Zannino, Jr.
263 S. Conkling Street, Baltimore, Maryland 21224

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on eech line. | Approximate Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death): a. Multiple injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

b.

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): 12-16-99

28b. Time of Injury: 1144 M

28c. Injury at Work? 1 [X] Yes 2 [ ] No

28d. Describe how injury occurred: subject fell from girder

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Construction Site

28f. Location (Street and Number or Rural Route Number, City or Town, State): 7600 Clark Road Hanover, Maryland

29a. Certifier (Check only one): 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner es steted. (1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted.)

29b. Signeture end title of certifier: Stephen S. Radentz, MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): December 18, 1999

30. Name and address of person who completed cause of death (Item 29a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: G Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39904

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Teresa Marie Green
2. Data of Death Month Day Year: December 18, 1999
3. Time of Death: 2:15 p.m.
4a. Facility Name (If not institution, give street and number): 360 South Cornwall Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 212-20-5461
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Dec. 5, 1909
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10a. Street and Number: 360 South Cornwall Street
10f. Zip Code: 21224
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): House Wife
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Dasch
18. Mother's Name (First, Middle, Maiden Surname): Marie Jurs

19a. Informant's Name/Relationship (Type, Print): Maryland Joyce Atrwell (niece)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 360 South Cornwall Street, Baltimore, Maryland 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Sacred Heart of Jesus
Data: 12/21/99
20c. Location - City or Town, State: Baltimore. Maryland

21. Signature of Funeral Service Licensee: ▶ John W. Burkowske
22. Name and Address of Facility: Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Sepsis — 5 days

Due to (or as a consequence of):
b. Sacral decubitus stage IV — > 3 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: bedridden

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Sevil Yasar MD
29c. License number: D-54067
29d. Date signed (Month, Day, Year): December 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SEVIL YASAR, JHBMC Geriatric Div, 5505 Bayview Circle, Baltimore MD 21224

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: ▶ [signature] Spaks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39905

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: VERNA Guzman

2. Date of Death Month Day Year: December 18, 1999

3. Time of Death: 5:45pm

4a. Facility Name *(If not institution, give street and number)*: Lorien Nursing Home

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 458-03-9714

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs. | If Under 1 Yaer: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: June 11, 1916

9. Birthplaca *(State or Foreign Country)*: Texas

Usual Residence of Decedant

10a. State: MD.

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 8893 Flowerstock Row, Apt. 104

10f. Zip Code: 21045

10g. Citizan of What Country?: U.S.A.

11. Meritel Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☒ Yas 2☐ No Specify: Spanish

14. Race - American Indian, Black, Whita, atc. Specify: white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 7 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: printer

16b. Kind of Business/Industry: advertising

17. Father's Nema *(First, Middle, Last)*: Raymond Garcia

18. Mother's Name *(First, Middle, Maiden Surname)*: Ida Ninio

19a. Informant's Name/Reletionship *(Type, Print)*: Miguel R. Guzman, husband

19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8893 Flowerstock Row, Apt. 104, Columbia, Md.21045

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: St. Louis Cemetery

Data: 12/22/99

20c. Location - City or Town, Stata: Clarksville, MD.

21. Signature of Funeral Sarvice Licensee: Sandra L Lemmer

22. Nama and Address of Facility: Witzke Funeral HOme, Inc. 5555 Twin Knolls Rd., Columbia, Md. 21045

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused tha death. Do not entar tha moda of dying, such as cardiac or raspirafory arrest, shock, or heart failura. List only ona cause on aach line.

Approximate Interval Between Onset and Death

Immediata Causa (Finai diseasa or condition resulting in death)

a. SEPSIS — SHOCK

Due to (or as a consequance of):

b. ATHEROSCLEROSIS — YEARS

Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initieted evants resulting in death) Last

Dua to (or as a consequence of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

Diabetes Mellitus

Encephalitis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to complation of causa of death? 1☐ Yas 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

25. Was casa rafarred to medical examiner? 1☐ Yas 2☒ No

26. Placa of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Rasidance 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Cartifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the tima, data and placa, and dua to tha ceuse(s) and menner stated.

29b. Signeture end title of certifier:

29c. License number: D22856

29d. Deta signed *(Month, Day, Year)*: December 20, 1999

30. Neme end address of person who completed causa of death (Item 23a) (Type, Print): Jerry L Ecuse, MD 11055 Little Patuxent Pky Columbia, Md 21044

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 21 1999

32. Registrars Signatura: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39906

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Vera Groont
2. Data of Death Month Day Yaar: December 17 1999
3. Time of Death: 12:44 pm

4a Facility Name (If not institution, give street and number): Crofton Convalescent & Rehabilitation Ctr
4b. City, Town, or Location of Death: Crofton
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 131-10-2649
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Feb.21 1921
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Crofton
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 1464 Vineyard Court
10f. Zip Code: 21114
10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☐ No If Yes, Giva Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:
14. Raca - Amarican Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Textile Design Artist
16b. Kind of Businass/Industry: Textile

17. Father's Nama (First, Middle, Last): Julius Nemetz
18. Mothar's Nama (First, Middle, Maiden Surname): Bella Schmenick

19a. Informant's Name/Ralationship (Type, Print): Ralph Groont (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1464 Vineyard Court, Crofton, MD 21114

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Carmel Cemetery
Date: 12/20
20c. Location - City or Town, State: Glendale, NY

21. Signature of Funeral Service Licensee: ▶ Michele D. Kotta
22. Nama and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only one ceuse on each line. | Approximata Interval Between Onset and Death

Immediata Cause (Final diseasa or condition rasulting in death): a. Congestive Heart Failure — 1 year
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa given in Part I.: Renal failure,

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yas 2☒ No

25. Was casa refarrad to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Homa 5☐ Rasidence 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be determined
28a. Data of Injury (Month, Day Year)
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledga, death occurrad at tha tima, data and place, and dua to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or invastigation, in my opinion, death occurrad at tha tima, date and place, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: D 38958
29d. Data signed (Month, Day, Year): 12/18/99

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Daniel Simon Sieben 1413 Annapolis Road #106, odenton MD 21113

State Registrar

31. Data filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: Jenna G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39907

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jordan C. Hithon

2. Date of Death Month / Day / Year: December 19, 1999

3. Time of Death: 3:20pm

4a. Facility Name *(If not institution, give street and number)*: Baltimore VA Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-28-1028

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 68 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 09-24-1931

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street end Number: 908 Wicker Rd.

10f. Zip Code: 21144

10g. Citizen of Whet Country?: USA

11. Marital Status: XX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yas, Give Year or Dates: Army 4-26-1954 3-31-1962

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1 ☐ Yes ☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elamantary/Secondary (0-12): 12 th — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: Laborer

16b. Kind of Business/Industry: Carpentry

17. Father's Name *(First, Middle, Last)*: Julius Hithon

18. Mother's Name *(First, Middle, Maiden Surname)*: Adis McCormick

19a. Informant's Name/Ralationship *(Type, Print)*: William McCormick (Brother)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 908 Wicker Rd. Severn, Maryland 21144

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cronsville Vet. Cem. — Date: 12/23/99

20c. Location - City or Town, State: Cronsville, Maryland

21. Signature of Funaral Sarvica Licensee: [signature]

22. Name end Address of Facility: Caple Funeral Service, 5502 Winner Ave. Balto., Md. 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only ona causa on aach line.

Approximete Interval Between Onsat and Daath

Immediata Causa (Final disease or condition rasulting in daath)
a. Cancer - Uncertain Primary

Dua to (or as a consaquence of):
b. Emphysema

Sequentially list conditions, if eny, leading to immediate ceusa. Entar Underlying Causa (Diseasa or Injury that initiated evants resulting in deeth) Lest
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Mannar of Death: 1 ☒ Naturel 2 ☐ Accident 3 ☐ Sulcide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Streat and Number or Rural Route Number, City or Town, State)*

29a. Cartifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at tha tima, date and place, and dua to tha ceusa(s) and manner as steted. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end dua to the cause(s) end manner stated.

29b. Signature and title of certifier: Nia Jewell

29c. License number: 116605

29d. Date signed *(Month, Day, Year)*: 12/19/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nia Jewell 116 S. Eutaw St, Baltimore, MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 21 1999

32. Registrar's Signature: [signature] G Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

To Be Completed by Funeral Director

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

RKD

99-7391-031

HAROLD HOCK

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G79 1-5-2000 WR.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39908

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Harold Edward Hock

2. Date of Death Month Day Year: DECEMBER 7,1999

3. Time of Death: 11:25A.M.

4a Facility Name (If not institution, give street and number): 3027 MOZART DRIVE

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 523-60-1724

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 53 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCT 27, 1946

9. Birthplace (State or Foraign Country): Colorado

To Be Completed by Funeral Director

Usual Rasidance of Dacedant

10a. Stata: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 [ ] Yas [X] No

10e. Street and Number: 3027 Mozart Drive

10f. Zip Code: 20904

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Nevar Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1 [ ] Yas 2 [X] No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired): Defense Intelligence Agency

16b. Kind of Business/Industry: Federal Government

17. Fathar's Nama (First, Middla, Last): Edward Hock

18. Mothar's Nama (First, Middla, Maidan Surnama): Rebecca Unk.

19a. Informant's Name/Ralationship (Type, Print): Lisa A. Umphrey/daughter

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 1275 Dancing Horse Dr., Colorado Springs, CO 80919

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Place of Disposition (Nama of cematary, crematory or othar place): Metro Crematory, Inc. Data: 12/21/99

20c. Location - City or Town, Stata: Baltimore, MD

21. Signature of Funaral Service Licensee: Edward A. Gregorchik

22. Nama and Addrass of Facility: Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that ceused tha daath. Do not entar tha mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona cause on aach lina.

Approximata Interval Between Onset and Death

Immediata Causa (Final disaasa or condition resulting in daath): a. COMBINED DRUG INTOXICATION

Dua to (or as a consequance of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiated evants resulting in death) Last

b. Dua to (or as a consequence of):

c. Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying ceusa given in Part I.: HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yas 2 [ ] No

24b. Wara autopsy findings available prior to complation of cause of death? 1 [X] Yas 2 [ ] No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was cesa rafarred to medical examinar? 1 [X] Yas 2 [ ] No

26. Placa of Death (Check only ona): Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA Other: 4 [ ] Nursing Homa 5 [X] Rasidence 6 [ ] Othar (Specify)

27. Mannar of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicida 4 [ ] Homicida 5 [ ] Panding invastigation 6 [ ] Could not be datarmined

28a. Data of Injury (Month, Day, Year): Found: 12-7-99

28b. Tima of Injury: Found: 11:00 A M

28c. Injury at Work? 1 [ ] Yas 2 [X] No

28d. Describe how injury occurred: UNKNOWN

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify): RESIDENCE

28f. Location (Street and Number or Rural Route Number, City or Town, Stata): 3027 MOZART DR. SILVER SPRING MD

29a. Cartifiar (Check only one): 1 [ ] **Certifying Physician:** To tha best of my knowledge, death occurred at the tima, data and place, and dua to tha ceusa(s) and mannar as stated. 2 [X] **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, data and place, and dua to the cause(s) and mannar stated.

29b. Signatura and title of certifiar: Theodore M. King

29c. Licansa number: O.C.M.E.

29d. Data signed (Month, Day, Year): DECEMBER 8,1999

30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print): THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39909

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Michael James Herrick

2. Date of Death (Month, Day, Year): DECEMBER 17, 1999

3. Time of Death: 3:40p.m

4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 217-64-1121

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 46 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN 29, 1953

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Edgewood

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10a. Street and Number: 350 Laburnum Road

10f. Zip Code: 21040

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Construction Work

17. Father's Name (First, Middle, Last): Earle Herrick

18. Mother's Name (First, Middle, Maiden Surname): Margaret Anna Willheim

19a. Informant's Name/Relationship (Type, Print): Margaret Anna Gover/mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4101 Southern Avenue Baltimore, MD 21206

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Metro Crematory, Inc.

Date: 12/20/99

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald

Dawn F. McDonald

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardio Pulmonary Arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Acute Myocardial Infarction

Due to (or as a consequence of):

c. Massive Pulmonary Edema

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] **Yes** 2 [ ] **No** 3 [ ] **Probably** 4 [ ] **Unknown**

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M. Alikhan

29c. License number: D14754

29d. Data signed (Month, Day, Year): 12-17-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MAHMOOD ALIKHAN, M.D GBMC 6701, N. Charles St Balt. MD

State Registrar

31. Data filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 10g, 12/21/99, G778, per F.H. **Certificate of Death**

Reg. No. 99 39910

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Talana	Lee	Hemphill	DECEMBER 17 1999	18:45

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ST AGNES HEALTHCARE	BALTIMORE	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-74-4462	1☐ M 2☒ F	40 Yrs.			11 20 59	M.D.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2100 Garrison Blvd	21216	~~I. S.A.~~ USA

11. Meritel Stetus	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Detes:	1☐ Yes 2☒ No Specify: XX	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
12th grade	1yr	Cook	Wendy's Restaurants

17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Fred Hemphill Jr.	Dolliy Mae Carey

19e. Informent's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ida Everette-Aunt	1819 Ruxton Ave, Baltimore Md 21216

20e. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)	King Memorial Park	12/21/99	Randallstown, Md

21. Signature of Funaral Sarvice Licensee: Shannon Stokes

22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

25a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one ceuse on eech line.

		Approximete Interval Between Onset and Death
Immedlete Ceuse (Finel diseese or condition resulting in deeth)	a. SEPTIC SHOCK	HOURS
Due to (or es a consequence of):	b. END STAGE RENAL FAILURE	MONTHS
Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Lest	c. RESPIRATORY FAILURE	HOURS
Due to (or es a consequence of):	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Wes case referred to medical exeminer?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated. 2☐ **Medical Examiner:** On the besis of exemineticn and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MEDICAL RESIDENT	P13605	DECEMBER 17, 1999

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): EVARISTUS NWULIA, MD, ST AGNES HEALTHCARE, 900 CATON AVENUE, BALTIMORE, MD 21229

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrer's Signature
DEC 21 1999	G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

NAME TALANA HEMPHILL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39911

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WANDA JEAN HORNER
2. Date of Death Month Day Year: December 15 1999
3. Time of Death: 12:45 PM
4a. Facility Name *(If not institution, give street and number)*: Union Memorial Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 283-32-5053
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 8, 1935
9. Birthplace *(State or Foreign Country)*: Ohio

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3600 Tenth Street
10f. Zip Code: 21225
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Unknown; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Receptionist
16b. Kind of Business/Industry: Legg Mason

17. Father's Name *(First, Middle, Last)*: James Kelly Owens
18. Mother's Name *(First, Middle, Maiden Surname)*: Birtie Louise Kimbleton

19a. Informant's Name/Relationship *(Type, Print)*: Freddie J. Horner (Husband)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3600 Tenth St., Baltimore, Md. 21225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lakeview Memorial Gdns.
Date: 12/18/99
20c. Location - City or Town, State: Sykesville, Maryland

21. Signature of Funeral Service Licensee: Kevin E. Ecker
22. Name and Address of Facility: McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Balto., Md. 21225-1856

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cerebrovascular accident — 10 days

Due to (or as a consequence of):
b. ischemic cerebral disease — 1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d. metastatic adrenal carcinoma — 1 month

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
C.O.P.D.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] M.D.
29c. License number: D0020111
29d. Date signed *(Month, Day, Year)*: December 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAJA E. AYASH. 201 E. UNIVERSITY PARKWAY BALTIMORE MD 21218.

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 21 1999
32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Wanda Horner

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

AMENDED ITEM #5 PER FH G779 1/28/2000 AH

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39912

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): EMMA HARRIS
2. Dete of Deeth: Month DECEMBER Dey 17 Yeer 1999
3. Time of Deeth: 9:35 AM
4a. Facility Nema (If not institution, giva street end number): NORTHWEST HOSPITAL CENTER
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: ~~219-46-4378~~ 215-40-3555
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 52 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): 5-5-47
9. Birthplece (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☑ No
10e. Street end Number: 2231 Wheatley Drive - Apt. 202
10f. Zip Code: 21207
10g. Citizen of Whet Country?: U.S.A.

11. Merital Status: 1☐ Never Merried 2☑ Merried 3☐ Widowed 4☐ Divorced
12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - Americen Indien, Black, White, etc. Specify: Black

15. Decedent's Eduction (Specify only highest grede completed): Elementary/Secondary (0-12) / College (1-4or 5+): 1
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Child Care Provider
16b. Kind of Business/Industry: Phyllis Wheatley Child Care

17. Fether's Neme (First, Middle, Last): George Johnson
18. Mother's Name (First, Middle, Maiden Sumame): Elizabeth Johnson

19a. Informent's Name/Relationship (Type, Print): Rodney T. Harris, Sr. / Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 2231 Wheatley Drive, Apt. 202, Baltimore, MD 21207

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Plece of Disposition (Neme of cemetary, cremetory or other place): Mt. Hope Cemetery
Dete: 12-23-99
20c. Location - City or Town, Stete: Princess Anne, MD

21. Signeture of Funeral Service Licensee: H H R
22. Neme and Address of Facility: Hari P. Close Funeral Service 709 Tessten St., Baltimore, MD 21201

Physician /Medical Examiner

23e. Pert 1. Enter the diseese, or complications that causad the death. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, shock, or heart feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Finel diseese or condition resulting in deeth):
a. Cardiac arrhythmia — Minutes

Due to (or as e consequence of):
b. Hyperkalemia

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest
Due to (or as e consequence of):
c. Hypertrophic cardiomyopathy

Due to (or as e consequence of):
d.

Pert II. **Other significant conditions** contributing to deeth but not resulting in tha underlying causa given in Part I.
End-stage renal disease
Diabetes Mellitus

23b. Did tobacco use contribute to tha causs of deeth? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en autopsy performed? 1☑ Yes 2☐ No
24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1☑ Yes 2☐ No

25. Wes case referred to medicel exeminer? 1☐ Yes 2☑ No
26. Plece of Deeth (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the besis of exemination end/or investigation, in my opinion, death occurred et the time, dete end plece, and dua to tha cause(s) end manner stated.

29b. Signeture and title of certifier: P. McDowell, M.D.
29c. License number: D47221
29d. Date signed (Month, Day, Year): December, 19, 1999

30. Neme and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): Philip McDowell, M.D. Northwest Hospital Center Randallstown Maryland

State Registrar

31. Data filed (Month, Day, Year): DEC 21 1999
32. Registrer's Signeture: Brenda G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39913

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth May Hart
2. Date of Death (Month, Day, Year): December 17, 1999
3. Time of Death: 8:55 a.m.
4a. Facility Name (If not institution, give street and number): Manor Care - Rossville
4b. City, Town, or Location of Death: Rossville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-16-4268
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 18, 1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore,
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 322 Leeanne Road
10f. Zip Code: 21221
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): House wife
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Walter Williams
18. Mother's Name (First, Middle, Maiden Surname): Lillian M. Cassidy

19a. Informant's Name/Relationship (Type, Print): James N. Hart (husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 322 Leeanne Road, Baltimore, Maryland 21221

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hill Mem. Gardens
Date: 12/20/99
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	a. Ischemic Cardiomyopathy	3-4 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet Initieted events resulting in death) Last	b. Coronary artery disease	4-5 yrs.
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HTN, Severe COPD.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: D-38754
29d. Date signed (Month, Day, Year): 12-17-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MALIKA WASSEM. 406. EASTERN BLVD. BALTIMORE MD-21221

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: [signature] G Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39914

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Carmelita Hayden

2. Date of Death: Month Dec Day 19 Year 99

3. Time of Death: 9:25 pm

4a. Facility Name (If not institution, give street and number): Charlestown Care Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore?

Funeral Director

5. Social Security Number: 216-36-5737

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 07/16/1905

9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md

10b. County: Baltimore

10c. City, Town or Location: Pikesville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 229 Sudbrook Lane

10f. Zip Code: 21208

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookkeeper

16b. Kind of Business/Industry: Banking

17. Father's Name (First, Middle, Last): Albert Andrews

18. Mother's Name (First, Middle, Maiden Surname): Mary Ellen Moran

19a. Informant's Name/Relationship (Type, Print): Benjamin Hayden, III/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) N.Y. P.O.Box 1672 South Road Branch Poughkeepsie

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cem

Date: 12/23

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc 736 Edmondson Avenue, Balto, Md. 21228

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Gastric Cancer — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D 51051

29d. Date signed (Month, Day, Year): December 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andres Salazar 711 Maiden choice Lane, Catonsville, MD, 21228

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Name: Mary C. Hayden

12

AH

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39915

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Heagerty
2. Date of Death Month Day Year: 12 - 16 - 99
3. Time of Death: 8:05PM
4e. Facility Name (If not institution, give street and number): Rock Glen Nursing Home
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 220-07-2907
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 10, 1919
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 10 N. Rock Glen Road
10f. Zip Code: 21229
10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Raca - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired): Secretary
16b. Kind of Business/Industry: B & O Railroad

17. Father's Neme (First, Middle, Last): Thomas Heagerty
18. Mother's Name (First, Middle, Maiden Surneme): Elizabeth McAuliffe

19a. Informent's Neme/Reletionship (Type, Print): Doris Gately (Cousin)
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 4740 Gawain Drive, Ellicott City, MD 21043

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): New Cathedral Cemetery
Dete: 12/21/99
20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funeral Service Licensee:
22. Name end Address of Fecility: Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximete Intervel Between Onset end Death

Immediete Ceuse (Finel disease or condition resulting in deth)
a. Atherosclerotic Cardiovascular disease

Due to (or as e consequence of):
b.

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Lest
Due to (or es a consequence of):
c.

Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Anemia.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated.

29b. Signature and title of certifier: Aleyamma J. mathew
29c. License number: D27716
29d. Date signed (Month, Day, Year): 12-17-99

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): 5411 Old Frederick Rd. Baltimore MD 21229

State Registrar

31. Dete filed (Month, Day, Year): DEC 21 1999
32. Registrer's Signeture: Jenita G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39916

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Annie M. Huggins
2. Data of Death Month Day Year: DEC. 19, 1999
3. Time of Death: 12(NOON)
4a. Facility Name (If not institution, give street and number): JOSEPH RITCHIE HOSPICE
4b. City, Town, or Location of Death: BALTO.
4c. County of Death:

Funeral Director

5. Social Security Number: 219-26-6572
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): JAN. 23, 1939
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residance of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 514 N. PATTERSON PK. AVE.
10f. Zip Code: 21205
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: AFRO-AMERICAN
15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 12TH | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired): SUPPLY OPERATOR
16b. Kind of Business/Industry: SOCIAL SECURITY
17. Father's Nama (First, Middle, Last): MATTHEW HUGGINS
18. Mother's Name (First, Middle, Maiden Surnama): ANNIE LAWRENCE
19a. Informant's Name/Relationship (Type, Print): ANGELA P. ONOKALA/DAUGHTER
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 514 N. PATTERSON PK. AVE. BALTO, MD. 21205
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Othar (Specify)
20b. Placa of Disposition (Name of cemetery, crematory or other placa): GREEN MOUNT CREMATORY
Date: DEC. 23, 1999
20c. Location - City or Town, State: BALTO, MD.
21. Signature of Funeral Service Licansee: Bernadine V. Scruggs
22. Nama and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213

Physician /Medical Examiner

23a. Part I. Enter tha disaase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on each line.

Approximate Interval Between Onset and Death

Immediate Causa (Final disease or condition resulting in death)
a. End-stage renal disease, with multiple areas of sepsis — 2 weeks
Due to (or as a consequanca of):
Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Causa (Disaase or injury that initiated evants resulting in death) Last
b. Insulin-dependent diabetes — 4 years
Due to (or as a consequanca of):
c.
Due to (or as a consequanca of):
d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.
Small cell carcinoma (B) upper lung lobe
Hepatitis C

23b. Did tobacco use contributa to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of daath? 1☐ Yes 2☐ No

25. Was casa rafarrad to medical examiner? 1☐ Yes 2☒ No
26. Place of Daath (Check only ona) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Home 5☐ Residanca 6☒ Other (Specify) Hospice
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarminad
28a. Date of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, streat, factory, office building, atc. (Spacify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifiar (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at tha time, data and placa, and dua to the causa(s) and mannar as statad. 2☐ **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, daath occurred at the time, date and placa, and dua to tha causa(s) and manner stated.
29b. Signatura and titla of certifier: Rolfe B. Finn, M.D.
29c. Licanse number: D02175
29d. Data signad (Month, Day, Year): 12-14-99
30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Rolfe B. Finn, M.D. 8526 Winands Road, Randallstown, MD 21133

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

ANNIE HUGGINS DECEMBER 19, 1999 12:01 PM

10

AH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39917

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gerhard Hoffmann

2. Date of Death: Month December Day 20 Year 1999

3. Time of Death: 8:30 am

4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-22-4802

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 14, 1927

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3804 Wallford Drive, Apt. C

10f. Zip Code: 21222

10g. Citizen of What Country? United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12 years

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Wire Technician

16b. Kind of Business/Industry: Manufacturing

17. Father's Name (First, Middle, Last): Max Peter Hoffmann

18. Mother's Name (First, Middle, Maiden Surname): Elsie Bittner

19a. Informant's Name/Relationship (Type, Print): Debra M. Everetts (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1925 Rettman Lane Baltimore, Md. 21222

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore National Cemetery

Date: 12/22/99

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Gregory E. Ruck

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Septic Shock — 2 weeks

Due to (or as a consequence of):

b. Pneumonia — 2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Alan M. Weiss MD Resident Physician

29c. License number: 98033

29d. Date signed (Month, Day, Year): December 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alan M. Weiss MD, 4940 Eastern Ave., Baltimore, Maryland 21224

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: Gerald G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39918

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carl Huebner
2. Date of Death Month: 12 Day: 20 Year: 99
3. Time of Death: 340AM
4a. Facility Name (If not institution, give street and number): Franklin Woods
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-14-1113
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 9-2-1916
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 106 Bayside Drive
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Policeman
16b. Kind of Business/Industry: Law Enforcement

17. Father's Name (First, Middle, Last): Hugo Otto Huebner
18. Mother's Name (First, Middle, Malden Surname): Sarah Edwards

19a. Informant's Name/Relationship (Type, Print): Marie Huebner (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 106 Bayside Drive Baltimore, Maryland 21222

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp. Date: 12/21/99
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Greg E Ruda
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Congestive Heart Failure	2 mos
Due to (or as a consequence of):	b. Atherosclerotic Cardiovascular Disease	10 yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert C. Duck Jr.
29c. License number: D39660
29d. Date signed (Month, Day, Year): 12/20/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert C. Duck 7566 North Point Rd. Baltimore MD 21219

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: G. Sparks

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Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39919

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Harvey Franklin Henry	December 18, 1999	8:35 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1450 Burton Ave.	Lutherville	Baltimore Co.

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-28-8442	1 ☒ M 2 ☐ F	66 Yrs.			June 08, 1933	Ashland, Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore Co.	Lutherville	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1450 Burton Ave.	21093-5001	United States of America

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	n/a	Estimator	Construction

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Louis Franklin Henry	Mary Rebecca Riley

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Betty Lee(nee Henry)Henry(Wife)	1450 Burton Ave. Lutherville, Maryland 21093-5001

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Dulaney Valley Memorial Gardens	12/22/1999	Timonium, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Michael J Ruck	Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson,Md. 21204-2515

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lung Cancer	Months
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown	1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ A Sapos MD	037362	12/20/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Anthony Sapos MD 1205 York Rd 32c Lutherville Md 21093

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 21 1999	▶ B Sparks

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Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

MD HATZ

2

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39920

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARIA IBANEZ
2. Date of Death (Month, Day, Year): DECEMBER 20, 1999
3. Time of Death: 12:50 AM
4a. Facility Name (If not institution, give street and number): CHESAPEAKE HOSPICE HOUSE
4b. City, Town, or Location of Death: LINTHICUM
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 097-05-9401
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 3, 1914
9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: SEVERN
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7718 LOCUST WOOD ROAD
10f. Zip Code: 21144
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOME MAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): GELSOMINO CAPONEGRO
18. Mother's Name (First, Middle, Maiden Surname): UNKNOWN

19a. Informant's Name/Relationship (Type, Print): CAYETANO IBANEZ/HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7718 LOCUST WOOD RD. SEVERN, MD 21144

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY | Date: DEC. 21, 1999
20c. Location - City or Town, State: CATONSVILLE, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: KIRKLEY-RUDDICK FUNERAL HOME P.A. 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Cerebrovascular accident — 7 day
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D23624
29d. Date signed (Month, Day, Year): Dec 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BASANT K. KHANDELWAL, M.D. 1600 CRAIN HWY. S. GLEN BURNIE, MD 21061

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: [signature]

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ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39921

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Isaac LeRoy James
2. Date of Death Month Dec. Day 06 Year 99
3. Time of Death: 6:57AM
4a. Facility Name *(If not institution, give street and number)*: 3813 St. Barnabas Rd #202
4b. City, Town, or Location of Death: Suitland
4c. County of Death: Prince Georges'

Funeral Director

5. Social Security Number: 267-19-0785
6. Sex: X 1 M 2 F
7. Age *(In yrs. last birthday)*: 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb, 18 24
9. Birthplace *(State or Foreign Country)*: Jacksonville FL

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges'
10c. City, Town or Location: Suitland
10d. Inside City Limits: 1 X Yes 2 No
10e. Street and Number: 3813 St.Barnabas Rd., #202
10f. Zip Code: 20746
10g. Citizen of What Country?: USA

11. Marital Status: 1 Never Married 2 X Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify* Black
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Engineer
16b. Kind of Business/Industry: US GOVT.
17. Father's Name *(First, Middle, Last)*: Samuel James
18. Mother's Name *(First, Middle, Maiden Surname)*: Hattie Benjamin
19a. Informant's Name/Relationship *(Type, Print)*: Mary S. James - wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3813 St.Barnabas Rd,Suitland,MD 20746
20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Arlington Nat'l Cem.
Date: 12-13-99
20c. Location - City or Town, State: Arlington,VA
21. Signature of Funeral Service Licensee: John A Latney Jr 20348
22. Name and Address of Facility: Latney's Funeral Home 3831 Georgia Ave.,NW Wash.,DC 20011

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multiple myeloma — 2.5 yrs.

Due to (or as a consequence of):
Hypercalcemia — 6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes X 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes X 2 No

26. Place of Death *(Check only one)*: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA — Other: 4 Nursing Home X 5 Residence 6 Other *(Specify)*

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: X 1 **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Alfred B. Brooks MD
29c. License number: Co 24898
29d. Date signed *(Month, Day, Year)*: DEc. 8,1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alfred Brook,MD 6825 16th St.,NW Wash.,DC 20307-5001

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 21 1999
32. Registrar's Signature: Penny D Sparks

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39922

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES L. JENKINS
2. Date of Death Month Dey Year: December 18, 1999
3. Time of Death: 9:40pm
4a. Facility Name (If not institution, give street end number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: AA COUNTY

Funeral Director

5. Social Security Number: 219-22-5894
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 09 1928
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Anne Arundel Co.
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street end Number: 8 Senate Drive
10f. Zip Code: 21122
10g. Citizen of What Country?: USA

11. Maritel Stetus: 1 ☐ Never Married 2 X Merried 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indien, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 10 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sheet Metal Mechanic
16b. Kind of Business/Industry: Local 100

17. Fether's Neme (First, Middle, Last): James L. Jenkins
18. Mother's Name (First, Middle, Maiden Surneme): Emily Klausmeyer

19a. Informent's Neme/Reletionship (Type, Print): Mildred Jenkins (Wife)
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8 Senate Drive, Pasadena, Md. 21122

20a. Method of Disposition: 1 ☐ Burial 2 X Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Green Mount Cemetery
Dete: 12/22/99
20c. Location - City or Town, Stete: Baltimore, Md.

21. Signature of Funeral Service Licensee: Daniel A. Parks
22. Name end Address of Facility: McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that causpd the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final diseese or condition resulting in deeth): e. ACUTE MYOCARDIAL INFARCTION — Immediate
Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Last:
b. Due to (or es a consequence of):
c. Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Wes en autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Wes case referred to medical exeminer? 1 ☐ Yes 2 X No

26. Place of Death (Check only one): Hospitel: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Menner of Deeth: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigetion 6 ☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es stated. 2 ☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner steted.

29b. Signature and title of certifier: Ira E. Kaplan M.D.
29c. License number: D 25611
29d. Dete signed (Month, Dey, Year): December 20, 1999

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): IRA E. Kaplan, M.D. 7845 Oakwood Rd #300 Glen Burnie, MD 21061

State Registrar

31. Dete filed (Month, Day, Year): DEC 21 1999
32. Registrer's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

JENKINS JAMES
Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

10x1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39923

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bertha Helena King

2. Date of Death: Month 12 Day 20 Year 1999

3. Time of Death: 12:30 pm

4a. Facility Name (If not institution, give street and number): Carroll Lutheran Village 205 St Mark Way, Westminster #421

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 219-07-9673

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 23, 1920

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 205 St. Mark Way #421

10f. Zip Code: 21058

10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Disability Adjuster

16b. Kind of Business/Industry: Social Security

17. Father's Neme (First, Middle, Last): Frederick Memmert

18. Mother's Neme (First, Middle, Maiden Surneme): Helen Miller

19a. Informent's Neme/Reletionship (Type, Print): Sharlayne Redding - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 506 Glen Granite Rd., Reisterstown, Md. 21136

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Lorraine Park Cemetery Date: Dec. 23, 1999

20c. Location - City or Town, State: Woodlawn, Md.

21. Signeture of Funeral Service Licensee: H.J. Eckhardt

22. Neme end Address of Facility: Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Perts. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feilure. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediate Cause (Finel diseese or condition resulting in deeth): a. Acute Myocardial Infarction

Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Menner of Death: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred el the time, date end piece, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier

29c. License number: D37949

29d. Date signed (Month, Day, Year): Dec 20th 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alexander Bryla 205 St. Mark Way Westminster, Md. 21157

State Registrar

31. Date filed (Month, Dey, Year): DEC 29 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39924

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joanne I. Kline

2. Date of Death: Month Dec. Day 16 Year 1999

3. Time of Death: 10:20 AM

4a. Facility Name (If not Institution, give street and number): St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 205-22-9859

8. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 3, 1929

9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 506 Sunset Rd.

10f. Zip Code: 21223

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Alonzo Baumgardner

18. Mother's Name (First, Middle, Maiden Surname): Helen Watson

19a. Informant's Name/Relationship (Type, Print): Charles Kline Jr. / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 506 Sunset RD. Baltimore, MD 21223

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☒ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Entombment Loudon Park Cemetery

Date: 12-20-99

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Bernard Schwartz

22. Name and Address of Facility: Sterling-Ashton-Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Ventricular Fibrillation — 1 hr

Due to (or as a consequence of): A S Cr D — 15 yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Raymond D Bahr

29c. License number: D 590

29d. Date signed (Month, Day, Year): 12/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAYMOND D. BAHR

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME Kline, Joanne

5

AH

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39925

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Madelyn Loomis Langdon

2. Date of Death Month: DEC Day: 15 Year: 99

3. Time of Death: 8:00 PM

4a. Facility Name *(If not institution, give street and number)*: St. Agnes HeAlthcare

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-30-3929

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: FEB 17, 1914

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2110 Drummond Road

10f. Zip Code: 21228

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Research

16b. Kind of Business/Industry: Johns Hopkins University

17. Father's Name *(First, Middle, Last)*: Ray W. Loomis

18. Mother's Name *(First, Middle, Maiden Surname)*: Edna Burkhart

19a. Informent's Name/Relationship *(Type, Print)*: Diane Rawlinson/daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3112 B Normandy Woods Dr., Ellicott City, MD 21043

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Loudon Park Cemetery Date: 12/20/99

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald

22. Name and Address of Facility: MacNabb Funeral Home, P.A. 301 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. SEPSIS — ONE MONTH

Due to (or as a consequence of):

b. ISCHAEMIC BOWEL DISEASE — ONE MONTH

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

ATRIAL FIBRILLATION

MOBITZ II HEART BLOCK

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D. MEDICAL RESIDENT

29c. License number: P-13603

29d. Date signed *(Month, Day, Year)*: DEC 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. CHARLES OWUSU, ST. AGNES HOSP. 900 CATON AVE. BALTIMORE

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 21 1999

32. Registrar's Signature: B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME LANGDON, MADELYN

12

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#8 PER F.H. G778 12-30-99 J.A.

Certificate of Death

Reg. No. 99 39926

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HARRY RAYMOND LOVE

2. Date of Death: Month DEC Day 17 Year 1999

3. Time of Death: 11:34AM

4a. Facility Name (If not institution, give street and number): ER FALLSTON GENERAL HOSPITAL

4b. City, Town, or Location of Death: FALLSTON

4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 219-01-3054

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10-15-14 ~~Oct. 14, 1915~~

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Glen Arm

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 11630 Glen Arm Road Apt. U 42

10f. Zip Code: 21057

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Plant Inspector

16b. Kind of Business/Industry: Baltimore Gas and Electric

17. Father's Name (First, Middle, Last): Raymond Paul Love

18. Mother's Name (First, Middle, Maiden Surname): Emma Wilhelmina Schmidt

19a. Informant's Name/Relationship (Type, Print): Joan Mellott/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5543 B New Park Road, White Hall, MD 21161

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. John's Church Cemetery

Date: Dec. 20, 1999

20c. Location - City or Town, State: Phoenix, MD

21. Signature of Funeral Service Licensee: Michael J. Flagle

22. Name and Address of Facility: Lemmon Funeral Home of Dulaney valley, Inc. 10 W. Padonia Road Timonium, MD 21093

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR

Due to (or as a consequence of): DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: DME

29c. License number: OCME

29d. Date signed (Month, Day, Year): DEC 17 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GPRABHU MD 218 Fulford AVE BELAIR MD 21014

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39927

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Henry Litke
2. Date of Death Month: 12 Day: 18 Year: 1999
3. Time of Death: 1:15 PM
4a. Facility Name (If not institution, give street and number): Maryland Masonic Homes
4b. City, Town, or Location of Death: Cockeysville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-07-3735
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11/25/1914
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Cockeysville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 300 International Circle
10f. Zip Code: 21030
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): n/a
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Tool Master
16b. Kind of Business/Industry: Bethlehem Steel

17. Father's Name (First, Middle, Last): Ferdinand Litke
18. Mother's Name (First, Middle, Maiden Surname): Emma Litke

19a. Informant's Name/Relationship (Type, Print): Gloria Diegel/Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8930 Carlisle Ave., Balto., MD 21236

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery
Date: 12/21/99
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Bryan W. Clary
22. Name and Address of Facility: Lemmon Funeral Home, 10 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Cerebral Vascular Disease

Due to (or as a consequence of):
b. Atherosclerotic Vascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Atrial fibrilation, CHF, Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R. Libertz, MD.
29c. License number: D21464
29d. Date signed (Month, Day, Year): 12/20/99

30. Name and address of person who completed cause of death (item 23a) (Type, Print): ROBERT LIBERTO, MD. 3508 BANK ST BALTO, Md 21224

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: G Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39928

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM EDWARD LARKINS, JR.

2. Date of Death: Month DECEMBER Day 19 Year 1999

3. Time of Death: 3:10 AM

4e Facility Name (If not institution, give street and number): EASTPOINT NURSING HOME

4b. City, Town, or Location of Death: DUNDALK

4c. County of Death: BALTIMORE COUNTY

Funeral Director

5. Social Security Number: 216-68-4737

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 43 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 28 1956

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1630 Webster Street

10f. Zip Code: 21230

10g. Citizen of What Country? USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Credit Manager

16b. Kind of Business/Industry: Lee Furniture

17. Father's Name (First, Middle, Last): William E. Larkins, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Nancy V. Lehman

19a. Informant's Name/Relationship (Type, Print): Nancy V. Kelley (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1630 Webster Street, Baltimore, Md. 21230

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery

Date: 12/22/99

20c. Location - City or Town, State: Brooklyn Park, Md.

21. Signature of Funeral Service Licensee: ▶ Daniel A. Polk

22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Genitourinary Hemorrhage	12 hrs.
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	Multiple Sclerosis	15 yrs.
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one) Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Robert Durt

29c. License number: D39660

29d. Date signed (Month, Day, Year): December 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Durt 901 E. Fort Ave Baltimore MD 21230

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: Jeanne G Marks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39929

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas R. Lusk
2. Date of Death: Month December, Day 19, Year 1999
3. Time of Death: 8:00am
4a. Facility Name (If not institution, give street and number): 123 Edgehill Road
4b. City, Town, or Location of Death: Sherwood Forest
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 224-60-2975
6. Sex: 1 XX M 2 ☐ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): June 6, 1920
9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Sherwood Forest
10d. Inside City Limits: 1 ☐ Yes 2 XX No
10e. Street and Number: 123 Edgehill Road
10f. Zip Code: 21405
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 4
18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Economist
16b. Kind of Business/Industry: US Treasury

17. Father's Name (First, Middle, Last): Frederick C. Lusk
18. Mother's Neme (First, Middle, Maiden Sumeme): Ada Rogers

19a. Informant's Name/Relationship (Type, Print): Margaret L. Lusk (Wife)
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 123 Edgehill Road, Sherwood Forest, MD 21405

20a. Method of Disposition: 1 ☐ Burial 2 XX Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Metro Crematory
Date: 12/20
20c. Locelion - City or Town, Slete: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas N Hardesty
22. Name end Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart teilure. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death): a. CACHEXIA of malignancy — 2wks.
Due to (or es e consequence of): Metastatic renal cell Carcinoma — 6 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. (1) Renal cell carcinoma — 1 year
Due to (or as e consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Non insulin dependent Diabetes Hypertension

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an eutopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings eveilable prior to completion of cause of deeth? 1 ☐ Yes 2 X No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Deeth (Check only one)
Hospitel: 1 ☐ Inpatient 2 ☐ ER/Oulpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) end menner es stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date and piece, and due to the ceuse(s) and menner steted.

29b. Signature and title of certifier: George C Samaras
29c. License number: D08314
29d. Dete signed (Month, Day, Year): 12/20/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): George C. Samaras MD 205 Ridgely Ave Annapolis, MD 21401

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39930

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): ARNOLD MAX LUCKNER

2. Date of Death Month: DECEMBER Day: 18 Year: 1999

3. Time of Deeth: 1:24 AM

4a. Facility Neme (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Locetion of Deeth: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 214-03-4405

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Day, Yeer): March 3, 1918

9. Birthpleca (State or Foreign Country): MD

Usuel Residence of Decedent

10a. Stete: MD

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 X Yes 2 ☐ No

10e. Street end Number: 6 Upland Road Unit D-1

10f. Zip Code: 21210

10g. Citizen of Whet Country?: United States

11. Maritel Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: WW II

13. Was Decadent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: WHite

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Millwright

16b. Kind of Business/Industry: General Motors

17. Fether's Neme (First, Middle, Last): Max Oswald Luckner

18. Mother's Name (First, Middle, Maiden Surname): Amelia Shotz

19a. Infoment's Name/Relationship (Type, Print): Mrs. Hilda Luckner/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 6 Upland Rd. Unit D-1 Baltimore, MD 21210

20a. Method of Disposition: 1 ☐ Burie! 2 X Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify)

20b. Placa of Disposition (Name of cemetery, crematory or other piece): Hilltop Service Corp. Date: 12/20/99

20c. Location - City or Town, Stete: Towson, MD

21. Signature of Funeral Service Licensee: Stephen D. Coster

22. Name end Address of Facility: Ruck Towson Funeral Home, Inc 1050 York Road Towson, Maryland 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ACUTE MYOCARDIAL INFARCTION — 19 HOURS

Due to (or as e consequenca of):

Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Last

b.

Due to (or es e consequenca of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditiona** contributing to deeth but not resulting in the underlying cause given in Part I.: HYPERTENSION

23b. Did tobacco use contribute to the causa of death? 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown

24e. Was en eutopsy performed? 1 ☐ Yes 2 X No

24b. Were eutopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was case referred to medical exeminer? 1 ☐ Yes 2 X No

26. Piece of Deeth (Check only one) Hospitel: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Menner of Deeth: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date end placa, and due to the cause(s) end menner es steted. 2 ☐ **Medical Examiner**: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, dete end piece, and due to the ceuse(s) end manner steted.

29b. Signeture end title of certifier: Loveen Puthumana M.D

29c. License number: AT 2438946 P4

29d. Date signed (Month, Day, Year): DECEMBER 18 1999

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print): LOVEEN J PUTHUMANA, DEPT OF MEDICINE, UNION MEMORIAL HOSPITAL

State Registrar

31. Dete filed (Month, Day, Year): DEC 21 1999

32. Registrer's Signature

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39931

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Albert Franklin Lowe, Sr.

2. Data of Death — Month: December Day: 18 Year: 1999

3. Time of Death: 2:50 AM.

4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219 05 0550

6. Sex: 1 ☐ M 2 ☐ F — X

7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: July 8, 1912

9. Birthplace *(State or Foreign Country)*: Baltimore City, Md.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore County

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 8211 Loch Raven Blvd. Apartment AT

10f. Zip Code: 21286

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 6 — College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Shipping Clerk

16b. Kind of Business/Industry: Hecht Co.

17. Father's Name *(First, Middle, Last)*: George E. Lowe

18. Mother's Name *(First, Middle, Maiden Surname)*: Olivia Foxwell

19a. Informant's Name/Relationship *(Type, Print)*: Dorothy Sparks (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2029 Wintergreen Place Baltimore, Maryland 21237

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Glen Haven Mem. Park — Date: December 21, 1999

20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: Walter Lassahn Chappell

22. Name and Address of Facility: Lassahn Funeral Home, Inc. 7401 Belair Road Baltimore, Maryland 21236

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Post Extubate Respiratory Failure	10 minutes
Due to (or as a consequence of): b.	Congestive Heart Failure	14 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Massive Myocardial Infarction	
d.	Peripheral Vascular Disease	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Atrial Fibrillation
Tuberculosis

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)* — Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mohsen Ghafouri

29c. License number: RD 198945

29d. Data signed *(Month, Day, Year)*: 12/18/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Mohsen Ghafouri 9000 Franklin Square Dr. Baltimore, Maryland 21237

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 21 1999

32. Registrar's Signature: Penny G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Albert T Lowe

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39932

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alexander Maye
2. Date of Death: Month December Day 13 Year 1999
3. Time of Death: 9:30pm
4a. Facility Name (If not institution, give street and number): Sinai Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 240-80-0346
6. Sex: 1☐M 2☐F — X
7. Age (In yrs. last birthday): 51 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11-12-1948
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: X☐Yes 2☐No
10e. Street and Number: 2434 Garrison Ave.
10f. Zip Code: 21215
10g. Citizen of Whet Country?: USA

11. Meritel Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Reca - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+): 1yr
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpet Installer
16b. Kind of Businass/Industry: Flooring

17. Father's Neme (First, Middle, Last): Frederick Maye Sr.
18. Mother's Name (First, Middle, Maiden Surneme): Iceleen White

19a. Informent's Neme/Ralationship (Type, Print): Victoria Maye (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 2434 Garrison Ave. Balto., Md. 21215

20a. Mathod of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from State 4☐Donetion 5☐Othar (Specify)
20b. Place of Disposition (Name of cemetary, cremetory or other place): Maryland Veterans Cem
Data: 12/17/99
20c. Location - City or Town, State: Crownsville, Md.

21. Signature of Funaret Sarvice Licensee: [signature]
22. Name and Address of Facility: CAPLE FUNERAL SERVICE 5502 WINNER AVE. BALTO, MD 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such es cardiec or raspiretory errest, shock, or heart failure. List onty ona cause on aech tine. — Approximate Intarval Batween Onset end Death

Immediete Cause (Final disease or condition resulting in death): a. Intracerebral hemorrhage
Due to (or as e consequence of):
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or es a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part t.

23b. Did tobacco use contributa to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Wes en autopsy performed? 1☐Yas 2☑No
24b. Were autopsy findings availeble prior to completion of cause of daath? 1☐Yes 2☐No

25. Wes casa ratarred to medicat examiner? 1☐Yas 2☑No
26. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residenca 8☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piece of Injury - At homa, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑**Certifying Physician**: To the best of my knowledge, death occurred at the tima, data and place, and due to tha ceusa(s) and mannar as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end placa, end due to the cause(s) end manner steted.

29b. Signeture end title of certifier: [signature] Roedder MD, PhD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): DECEMBER 13, 1999

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): Sinai Hospital of Baltimore, Baltimore, MD

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signeture: [signature] Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

14X1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39933

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John marsh
2. Date of Death Month: 12 Day: 19 Year: 99
3. Time of Death: 12:10 Am
4a. Facility Name *(If not Institution, give street and number)*: Franklin Woods Center
4b. City, Town, or Location of Death: Balto., MD
4c. County of Death: Balto.

Funeral Director

5. Social Security Number: 162-18-8814
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 3 1919
9. Birthplace *(State or Foreign Country)*: PA

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Middle River
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 411 Bowleys Quarters Road
10f. Zip Code: 21220
10g. Citizen of What Country?: USA
11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Foreman
16b. Kind of Business/Industry: Beth Steel
17. Father's Name *(First, Middle, Last)*: Frank MArsh
18. Mother's Name *(First, Middle, Maiden Surname)*: Freda Eckstine
19a. Informant's Name/Relationship *(Type, Print)*: Frank MArsh / son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 411 Bowleys Quarters Road Baltimore MD. 21220
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gardens of Faith — Date: 12/21/99
20c. Location - City or Town, State: Rossville MD.
21. Signature of Funeral Service Licensee: R. Terry Connelly
22. Name and Address of Facility: Connelly Funeral Home of Essex 300 MAce Ave. Baltimore Md. 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. cerebro vascular Accident — 1 month.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

Bacteremia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S. Raguraj
29c. License number: D 0053720
29d. Date signed *(Month, Day, Year)*: 12/20/99.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. Raguraj, 2112 Belair Rd Suite #9, Fallston, MD 21047.

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 21 1999
32. Registrar's Signature: Penny B Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39934

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rose T. Miller

2. Date of Death (Month, Day, Year): December 19, 1999

3. Time of Death: 5:30am

4a. Facility Name (If not institution, give street and number): Catonsville Commons

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-07-1459

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 19, 1914

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 16 Fusting Avenue

10f. Zip Code: 21228

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Joseph Camella

18. Mother's Name (First, Middle, Maiden Surname): Margaret Crafton

19a. Informant's Name/Relationship (Type, Print): M. Corinne Hutchins (Guardian)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6161 Beechwood Drive, Ridge Manor, FL 33525

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore Washington Crematory

Date: 12/21/99

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Bryan W. Clary

22. Name and Address of Facility: Lemmon Funeral Home, 10 West Padonia Road, Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial infarction — minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Advanced Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: B. Turakhia, M.D.

29c. License number: D36942

29d. Date signed (Month, Day, Year): 12/20/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): B. TURAKHIA, MD 1009, Frederick Rd, Catonsville, MD 21228

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39935

Certificate of Death

Reg. No.

MEWSHAW, WILBUR M.
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILBUR M. MEWSHAW
2. Date of Death (Month, Day, Year): December 20 1999
3. Time of Death: 7:40 Am.
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL CO.

Funeral Director

5. Social Security Number: 217-12-5134
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 24 1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Florida
10b. County: n/a
10c. City, Town or Location: Vero Beach
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 438 Bimini Cay Circle
10f. Zip Code: 32966
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates: X
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Independent Carrier
16b. Kind of Business/Industry: Sun Paper

17. Father's Name (First, Middle, Last): Joseph Newton Mewshaw
18. Mother's Name (First, Middle, Maiden Surname): Viola Porter

19a. Informant's Name/Relationship (Type, Print): Janet M. Uebersax (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8443 Alvin Court, Pasadena, Md. 21122

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount Cemetery
Date: 12/23/99
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: ▶ David A. Hoyle
22. Name and Address of Facility: McCully-Polyniak Funeral HOme P.A. 3204 Mountain Road, Pasadena, Md. 21122

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CHRONIC OBSTRUCTIVE LUNG DISEASE

Due to (or as a consequence of):
b. PNEUMONIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ MD
29c. License number: D43977
29d. Date signed (Month, Day, Year): December 20 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ayaz Dhrangi. 301 Hospital Drive. Glen Burnie. MD 21061

State Registrar

31. Date Filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39936

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ASTRID MARIE MILLER
2. Dete of Deeth: Month DEC Dey 18 Year 1999
3. Time of Death: 5:10pm
4a. Facility Name (If not institution, give street end number): GILCHRIST CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 207-18-7447
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11/07/1926
9. Birthplace (State or Foreign Country): PENNSYLVANIA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: TOWSON
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8 MAYAPPLE COURT
10f. Zip Code: 21286
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2YRS
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ADMINISTRATIVE SECTY.
16b. Kind of Business/Industry: SECRETARY

17. Father's Name (First, Middle, Lest): CHRISTIAN GREIF
18. Mother's Name (First, Middle, Maiden Surneme): MARIE HARHOLT

19a. Informant's Name/Relationship (Type, Print): STEPHANIE GARTMAN(DAUGHTER)
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 2218 BOXMERE RD. TIMONIUM,MD. 21093.

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): ST. JOSEPH'S FULLERTON
Date: 12/21/99
20c. Location - City or Town, State: FULLERTON,MD.

21. Signature of Funeral Sarvice Licensea: William R. Peiss III
22. Name and Address of Facility: HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO.,MD. 21212.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Causa (Final disease or condition resulting in death)
a. stomach cancer — 3 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last
b.
Due to (or as a consequenca of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other elgnificant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Placa of Daath (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and piece, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: H. Anthony Riley, MD
29c. Licensa number: D25205
29d. Date signed (Month, Day, Yeer): December 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. md 21204

State Registrar

31. Data filed (Month, Day, Year): DEC 21 1999
32. Registrer's Signatura: Jennie G Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the buriel-transit permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Miller, Astrid 12/9/99 5th pm

DHMH 16 Rev 6/95

99-7615-005
UNK 99-318
asp

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39937

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Frederick Moore
2. Date of Death (Month, Day, Year): DECEMBER 18 1999
3. Time of Death: 2340
4a. Facility Name (If not institution, give street and number): WORTHINGTON AVE & TIMBERKNOLL RD.
4b. City, Town, or Location of Death: Reisterstown
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 213-02-2795
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 33 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 25, 1966
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 13917 Hanover Pike
10f. Zip Code: 21136
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Painter
16b. Kind of Business/Industry: Painting

17. Father's Neme (First, Middle, Last): William Leonard Moore
18. Mother's Name (First, Middle, Maiden Sumeme): Betty Eugenia Smith

19a. Informent's Name/Reletionship (Type, Print): Jeffrey L. Bowers, Sr. -Brother
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 13917 Hanover Pike, Reisterstown, Md. 21136

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Metro Crematory | Date: Dec. 22, 1999
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: ▶ H. J. Eckhardt
22. Name and Address of Facility: Eckhardt Funeral Chapel 21117, 11605 Reisterstown Rd., Owings Mills, Md.

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complications that causad tha death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on eech tine. | Approximate Interval Between Onset and Deeth

Immediate Ceuse (Final diseese or condition resulting in death): a. Multiple Injuries
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Dua to (or as a consequence of):
c. Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medicat examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Rasidence 6 [X] Other (Specify) SCENE

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Dete of Injury (Month, Day Year): 12-18-99
28b. Time of Injury: 2150 M
28c. Injury et Work? 1 [ ] Yes 2 [X] No
28d. Describe how Injury occurred: Automobile accident
28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify): Street
28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Worthington/Timberknoll Baltimore County, Maryland

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) end manner es stated. 2 [X] Medicat Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, snd due to the cause(s) and menner steted.
29b. Signature and title of certifier: ▶ Dlyth L Nadg, MD
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): DECEMBER 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Yeer): DEC 21 1999
32. Registrar's Signeture: ▶ Jennie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39938

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH E. MICHAEL

2. Date of Death: Month 12 Day 18 Year 99

3. Time of Death: 8 54 AM

4a. Facility Name (If not institution, give street and number): Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 212-18-7958

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb.18,1917

9. Birthplace (State or Foreign Country): Balto. Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Reisterstown

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 38 Woodley Ave.

10f. Zip Code: 21136

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 11th Grade

College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Refuse Haller

16b. Kind of Business/Industry: Baltimore Co.Health Dept

17. Father's Neme (First, Middle, Last): Joseph E. Michael

18. Mother's Neme (First, Middle, Maiden Surname): Eva Redifer

19a. Informent's Neme/Reletionship (Type, Print): Mary L. Michael Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3237 42 St. Astoria N. Y. 11103

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other place): Carroll Cremation Ser.

Dete: 12/22/99

20c. Location - City or Town, Stete: Hampstead, Md.

21. Signature of Funeral Service Licensee: James B Eline

22. Name end Address of Facility: ELINE FUNERAL HOME 11824 Reisterstown Road Reisterstown, Md. 21136

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode ot dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in death)

a. BRONCHIAL COMPRESSION — WEEKS

Due to (or es e consequence ot):

b. LYMPHOMA — YEARS

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Last

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

NON INSULIN DEPENDENT DIABETES MELLITUS

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings eveileble prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Deeth (Check only one)

Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time ot Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, term, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) end manner es stated. 2 [ ] **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) end menner steted.

29b. Signature end title of certifier: MD

29c. License number: D01663

29d. Date signed (Month, Day, Year): 12/18/99

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): VINCENT J. FIOCCO JR 906C WASHINGTON RD WESTMINSTER, MD 21157

State Registrar

31. Dete filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

MICHAEL, Joseph E,
Division of Vital Records, P.O. Box 68760,

10

A14

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#19a,20b perFH G778 12/21/99 EW

Certificate of Death

Reg. No. 99 39939

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
DAVID	HERBERT	MARKS	DECEMBER	18,	1999	1:18 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NORTHWEST HOSPITAL CENTER	RANDALLSTOWN	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
034-20-2143	1☒ M 2☐ F	71 Yrs.			OCT. 21, 1928	MA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	REISTERSTOWN	1☐ Yes 2☒ No

10a. Street and Number	10f. Zip Code	10g. Citizen of What Country?
500 BERRYMANS LANE	21136	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
4		ENGINEER	ENGINEERING

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
THOMAS MARKS	ANNIE (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
LISA ~~MARKS~~ Davis / DAUGHTER	210 RITTERSLEA COURT - OWINGS MILLS, MD 21117

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	CHEB SHALOM MEMORIAL PARK	12/~~19~~/99	REISTERSTOWN, MD

21. Signature of Funeral Service Licensee: Paul Feldt

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. CARBON MONOXIDE INHALATION	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☐ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	12/18/99	12-1 P M	1☐ Yes 2☒ No	IN HOME ELECTRIC FIRE

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
AT HOME	BERRYMANS LANE REISTERSTOWN, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Charles F. O'Donnell MD	D-09383	December 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles F. O'Donnell MD 111 Hamlet Hill Rd Baltimore Md 21210

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 21 1999	Jeanne B Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#14&19a PER F.H. G779 1-7-2000 J.A.

Certificate of Death

Reg. No. 99 39940

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
Florence	Merchant	Dec. 20, 1999	3:00am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Spring Brook Adventist Nursing Home	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
181-16-2338	1☐ M 2☒ F	107 Yrs.			Jan. 16, 1892	PA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Bethesda Maryland	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10250 Lake View Drive	20817	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: ~~White~~ BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Office Manager	Unknown

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles Merchant	Alice Jeffries

19a. Interment's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Alice ~~Champ~~ CHAMP Alleyne / Niece	4311 Kinmont Landham Maryland 20706

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)	Woodlawn Cemetery	December 22, 1999	Pittsburgh, Pa

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Victor P. Doda, Jr.	Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Pneumonia	3 days.
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Impaired Gag Reflex	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia, Aortic Stenosis, Degenerative Arthritis.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D31001	December 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7500 Greenway Cntr. Dr. #430
Stuart J. Turkewitz, MD. Greenbelt, MD 20770.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 21 1999	Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39941

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Alvin Berton Nehus, Jr.

2. Date of Death Month / Day / Year: December 16, 1999

3. Time of Death: 9:30 P.M.

4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-62-3926

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 46 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct 25, 1953

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 350 Upperlanding Road

10f. Zip Code: 21221

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: Freight Co.

17. Father's Name *(First, Middle, Last)*: Alvin B. Nehus

18. Mother's Name *(First, Middle, Maiden Surname)*: Pearl Bedsworth

19a. Informant's Name/Relationship *(Type, Print)*: Pearl I. Nehus (mother)

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 350 Upperlanding Road, Baltimore, Maryland 21221

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holly Hill Mem. Gardens | Date: 12/20/99

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: [signature]

22. Name end Address of Facility: Bruzdzinski Funeral HOme, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock or heart failure. List only one cause on eech line. | Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)

a. Anoxic encephalopathy

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b. End stage Liver Disease

Due to (or es a consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D21242

29d. Date signed *(Month, Day, Year)*: 12/17/99

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Dr Gregory B. Kelly 9000 Franklin Square Drive Baltimore, MD 21237

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 21 1999

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Alvin Nehus

6

AH

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39942

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eloise Hurst Pittman
2. Date of Death (Month, Day, Year): December 17, 1999
3. Time of Death: 7:45pm
4a. Facility Name (If not Institution, give street and number): Manor Care - Ruxton
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-10-4159
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 25, 1910
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7001 North Charles Street
10f. Zip Code: 21204
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): n/a
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William Hurst
18. Mother's Name (First, Middle, Maiden Surname): Lola Williams

19a. Informant's Name/Relationship (Type, Print): LeVerne Eppley/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 510 Greenwood Road, Towson, MD 21204

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem. Grdns. | Date: 12/22/99
20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: Bryan W. Clary
22. Name and Address of Facility: Lemmon Funeral Home, 10 W. Padonia Road, Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Alzheimer's Disease — years.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A. H Ghiladi
29c. License number: D-12849
29d. Date signed (Month, Day, Year): 12-20-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A. Hamid Ghiladi, MD 7600 Osler Drive, suite 111, Towson, MD 21204

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: P Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39943

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ferdinand W. Pfaff
2. Date of Death (Month, Day, Year): December 15, 1999
3. Time of Death: 6:29am
4a. Facility Name (If not institution, give street and number): N. Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 189-32-7030
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 58 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 3, 1941
9. Birthplace (State or Foreign Country): Germany

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 138 Circle Road
10f. Zip Code: 21122
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates: 1966
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+): 2 years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Field Engineer
16b. Kind of Business/Industry: KCI Technology

17. Father's Name (First, Middle, Last): Andy Pfaff
18. Mother's Name (First, Middle, Maiden Surname): Annie Zellhuber

19a. Informant's Name/Relationship (Type, Print): Judy Pfaff Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 138 Circle Road Pasadena MD 21122

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Crematory
Date: 12/17/99
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Christina L. Hilton
22. Name and Address of Facility: McCully-Polyniak Funeral Home, PA 3204 Mountain Rd Pasadena MD 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction

Due to (or as a consequence of):
b. Atherosclerotic Heart Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Ventricular Arrhythmia

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Old Cerebrovascular Accident

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Salvador D. Remineyer MD
29c. License number: D0038912
29d. Date signed (Month, Day, Year): 12/16/99

30. Name and address of person who completed cause of death (item 23a) (Type, Print): 1720 Crain Highway Suite 204 Glen Burnie, Maryland 21061

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#23a perPhyG778 12/21/99 EW

Certificate of Death

Reg. No. 99 39914

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sarah J. Phiffer
2. Data of Death Month: Nov. Day: 20, Year: 99
3. Time of Death: 0221
4a. Facility Name (If not institution, give street and number): Sinai Hospital Of Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 212-28-3637
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 68 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): 05-03-31
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Insida City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 3488 Dolfield Avenue
10f. Zip Code: 21215
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☐ No If Yes, Giva Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yas 2☒ No Specify:
14. Race - American Indian, Black, White, atc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th Grade; College (1-4or 5+): NA
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired): Laundry
16b. Kind of Businass/Industry: Company

17. Father's Name (First, Middle, Last): Joseph Slaughter
18. Mothar's Nama (First, Middle, Maidan Surname): Frances Spriggs

19a. Informant's Name/Relationship (Type, Print): Alder J. Phiffer
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 21215: 3488 Dolfield Avenue Baltimore, Maryland

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or other place): Voshell Mem. Gardens
Data: 1-26-99
20c. Location - City or Town, Stata: Dundalk, MD

21. Signature of Funeral Service Licensee: Francis [illegible]
22. Nama and Addrass of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on aach lina.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Seizure

Dua to (or as a consequence of):
b. ~~Aspiration~~ RESPIRATORY FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Dua to (or as a consequence of):
c. ~~Respiratory Failure~~ DIABETES MELLITUS

Dua to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in tha underlying causa given in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yas 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Wara autopsy findings available prior to completion of causa of death? 1☐ Yas 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only ona)
Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to tha cause(s) and mannar as stated. 2☐ Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, data and place, and dua to tha causa(s) and manner stated.

29b. Signature and title of certifier: [illegible] MD
29c. License number: D0050693
29d. Data signad (Month, Day, Year): December 3, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alden G. Peoples, MD 2401 W. Belvedere Ave, Baltimore, MD 21215

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signatura: [illegible]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39945

Edward Paul

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward Paul
2. Deta of Deeth — Month: December, Dey: 19, Yeer: 1999
3. Time of Death: 3:00am
4e. Facility Neme (If not institution, give street end number): Union Memorial Hospital
4b. City, Town, or Location of Deeth: Baltimore
4c. County of Deeth: N/a

Funeral Director

5. Social Security Number: 216-28-2851
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 67 Yrs. — If Under 1 Year: Months / Deys; If Undar 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): DEC. 16, 1932
9. Birthplece (Stete or Foreign Country): Maryland

Usual Residence of Decedent

10e. Stete: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimor
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street end Number: 1103 Springfield Ave
10f. Zip Code: 21239
10g. Citizen of Whet Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Yaar or Dates: 3-5-53 - 1-6-55
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12th grade; College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Cook
16b. Kind of Business/Industry: Restaurant

17. Father's Neme (First, Middle, Last): James Paul
18. Mothar's Neme (First, Middle, Maiden Surneme): Ella Carter

19e. Informent's Neme/Relationship (Type, Print): Lucille Wright / Sister
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1103 Springfield Ave Baltimore, Md 21239

20e. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Crownsville Veterans Cemetery
Date: 12-23-99
20c. Location - City or Town, Stete: Crownsville, Md

21. Signature of Funeral Service Licensee: Greg Ehrin
22. Nama and Address of Facility: CNA Funa - Harris & Sons 5300 Belair Rd Baltimore, Md 21206

Physician /Medical Examiner

23e. Pert I. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Finel diseese or condition resulting in deeth):
a. Metastatic B-Cell Lymphoma — >1yr

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to Immediete cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Last:
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significent conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobacco uee contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were eutopsy findings eveilable prior to compiation of causa of deeth? 1 ☐ Yes 2 ☒ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Piece of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Manner of Deeth: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28e. Dete of Injury (Month, Day Yeer)
28b. Time of Injury
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, offica building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete end place, and dua to the ceuse(s) end menner es steted. 2 ☐ **Medical Examiner**: On the basis of exemination end/or investigetion, in my opinion, death occurred et the time, dete end piece, end due to the ceuse(s) end mennar steted.

29b. Signature and title of certifier: Joanne Watson MD
29c. Licensa number: AU4176435
29d. Date signed (Month, Day, Year): December 19, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Joanne Watson, MD UMH

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: Denise G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39946

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY ALICE PARKS

2. Date of Death (Month, Day, Year): DEC. 15 1999

3. Time of Death: 3.33pm

4a. Facility Name (If not institution, give street and number): KESWICK-MULTI CARE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-44-2578

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/14/1909

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 700 WEST 40TH STREET

10f. Zip Code: 21211

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2YRS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE

16b. Kind of Business/Industry: HOMEMAKER

17. Father's Name (First, Middle, Last): WILLIAM T. COULEHAN

18. Mother's Name (First, Middle, Maiden Surname): ALICE RIED

19a. Informant's Name/Relationship (Type, Print): ELLEN P. YOUNG(DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 NIGHTINGALE WAY B-7 LUTHERVILLE,MD. 21093.

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): DRUID RIDGE CEM.

Date: 12/18/1999

20c. Location - City or Town, State: PIKESVILLE,MD.

21. Signature of Funeral Service Licensee: William R. Lawson III

22. Name and Address of Facility: HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO.,MD. 21212,

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Progressive dementia — Due to (or as a consequence of): — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier: W. Anthony Riley, MD

29c. License number: D25205

29d. Date signed (Month, Day, Year): December 16, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): W. A. Riley GBMC 6781 N. Charles St. Balto. Md 21204

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: Brenda G Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39947

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Sarah A. Price
2. Data of Death Month / Day / Yaar: December 16 1999
3. Time of Death: 1:26am
4a. Facility Name *(If not institution, giva street and number)*: 3551-C Burr Court
4b. City, Town, or Location of Death: Ft. Meade
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 016-60-1947
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 36 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Yaar)*: April 28,1963
9. Birthplace *(Stata or Foraign Country)*: Massachusetts

Usual Residence of Decedent

10a. Stata: MD
10b. County: Anne Arundel
10c. City, Town or Location: Ft. Meade
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 3551-C Burr Court
10f. Zip Code: 20755-1237
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working lifa. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Nama *(First, Middla, Last)*: Arthur J. Healey, Jr.
18. Mother's Nama *(First, Middle, Maiden Sumama)*: Marlene Muchmore

19a. Informant's Name/Ralationship *(Type, Print)*: Michael Price (Husband)
19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3551-C Burr Court, Ft. Meade, MD 20755-1237

20a. Mathod of Disposition: 1☒ Buriat 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cematary, crematory or other place)*: Oak Grove Cemetery
Date: 12/20
20c. Location - City or Town, Stata: Medford, Massachusetts

21. Signature of Funaral Service Licensee: Michael P. Kutta
22. Nama and Addrass of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailura. List only one cause on each line. — Approximata Interval Batwean Onset and Death

Immediata Cause (Final disease or condition resulting in death)
a. Increased Intracranial Pressure

Dua to (or as a consequence of):
b. Central Nervous System Lymphoma (Non Hodgkins) — 18 months

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last
Dua to (or as a consequence of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa ratarrad to medical examiner? 1☐ Yes 2☒ No

26. Placa of Death *(Check only one)*
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Homa 5☒ Rasidence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, tarm, street, tactory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, death occurred at tha time, data and place, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier: Alfred B. Brooks MD
29c. License number: 24898
29d. Data signed *(Month, Day, Year)*: 12/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alfred B. Brooks, MD, Walter Reed Army Medical Center, 6825 16th Street, NW Washington, DC 20307

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 21 1999
32. Registrar's Signatura: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39948

Amend Item 12, 12/21/99, G778, per F.H. Gap

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Saira Qureshi

2. Data of Death Month/Day/Year: 12 20 99

3. Time of Death: 1:38pm

4a. Facility Name (If not institution, give street and number): Fallston Gen'l Hospital

4b. City, Town, or Location of Death: Fallston

4c. County of Death: Harford Co.

Funeral Director

5. Social Security Number: 219-49-8904

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): 11 05 12

9. Birthplace (State or Foreign Country): Pasikan

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore Co

10c. City, Town or Location: Kingsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11026 Old Landing Road

10f. Zip Code: 21087

10g. Citizen of What Country? Pasikan

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unemployed

16b. Kind of Business/Industry: Unemployed

17. Father's Name (First, Middle, Last): Abdul Hakin Qureshi

18. Mother's Name (First, Middle, Maiden Surname): Haleema Qureshi

19a. Informant's Name/Relationship (Type, Print): Naeem Qureshi-Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11026 Old Landing Road, Kingsville Md 21087

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bazurgwal Cemetery

Data: 12/26/99

20c. Location - City or Town, State: Gugrat, Punjab

21. Signature of Funeral Service Licensee: ▶ [signature] March

22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hypertensive Cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pneumonia

Due to (or as a consequence of):

c. Anorexia.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was case referred to medical examiner? 1☐ Yas 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] M.D

29c. License number: DO 2022, Md

29d. Data signed (Month, Day, Year): 12-21-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Leopoldo C Cruss M.D. 405 Stemmers Run Rd. Baltimore, Md, 21221

State Registrar

31. Data filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39949

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anna Blanche Ritchie

2. Date of Death Month: 12 Day: 15 Year: 1999

3. Time of Death: 10:40pm

4a. Facility Name (If not institution, give street and number): Maryland Masonic Homes

4b. City, Town, or Location of Death: Cockeysville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-22-7479

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 09/28/1906

9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Baltimore

10c. City, Town or Location: Cockeysville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 300 International Circle

10f. Zip Code: 21030

10g. Citizen of What Country? USA

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): Harry Torbert

18. Mother's Neme (First, Middle, Maiden Surneme): Carrie Wilson

19a. Informant's Name/Relationship (Type, Print): Earl Ritchie/Nephew

19b. Mailing Address (Street end Number or Rurai Route Number, City or Town, State, Zip Code): 507 S. Grove Ave., Barrington, IL 60010

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other piace): Baltimore-Washington Crematory

Date: 12/17/99

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Bryan W. Clary

22. Name and Address of Facility: Lemmon Funeral Home, 10 W. Padonia road, Timonium, MD 21093

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Vascular Deseasi +

Due to (or as a consequence of):

b. Dementia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or es e consequence of):

c.

Due to (or es a consequence of):

d.

Part II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Pert I.

Depression, glaucoma - blindness

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rurai Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: R. Liberto, MD.

29c. License number: D21464

29d. Dete signed (Month, Day, Year): 12/16/99

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): ROBERT LIBERTO, MD. 3508 Bank ST BALTO, Md 21224

State Registrar

31. Dete filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: Denise G Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39950

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DOMINICK A. RAIMONDO
2. Date of Death (Month, Day, Year): DECEMBER 18 1999
3. Time of Death: 9:27 AM
4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE, CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-16-0391
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 9-15-1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Eastwood
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7318 Bridgewood Drive
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No WWII
If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Railroad Conductor
16b. Kind of Business/Industry: Patapsco & Backriver

17. Father's Name (First, Middle, Last): Nunzio Raimondo
18. Mother's Name (First, Middle, Maiden Surname): Margaret Cammarato

19a. Informant's Name/Relationship (Type, Print): John A. Raimondo son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 419 Boat Dock Drive East, Angula Bythe Bay, Lewes, De.

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or othar place): Sacred Heart of Jesus
Data: 12/21/99
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Maria N. Zannino
22. Name and Address of Facility: Joseph N. Zannino Jr. Funeral Home, 263 S. Conkling Street, Baltimore, Maryland 21224

Physician /Medical Examiner

23a. Part1. Enter tha disaase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION — 3 days

Due to (or as a consequence of):
b. DIFFUSE ISCHAEMIC STROKE — 11 days

Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disaese or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. CORONARY ARTERY BYPASS — 11 days

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only ona)
Hospital: 1 [X] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending investigetion 6 [ ] Could not be datarmined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To tha best of my knowledge, death occurred at the tima, dale and place, and due to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Modern MD
29c. License number: 04590
29d. Data signed (Month, Dey, Year): DECEMBER 18 1999

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): JACQUES KPODONU THE JOHNS HOPKINS HOSPITAL

State Registrar

31. Dale filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39951

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John C. Roe, Jr.

2. Data of Death — Month: December; Day: 20; Yaar: 1999

3. Tima of Deeth: 6:50am

4a. Facility Nama *(If not institution, giva streat and numbar)*: Gilchrist Center

4b. City, Town, or Location of Daath: Towson

4c. County of Daath: Baltimore

Funeral Director

5. Social Security Number: 212-01-7437

6. Sax: 1☒ M 2☐ F

7. Aga *(In yrs. last birthday)*: 89 Yrs. — If Undar 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Yaer)*: Feb. 23, 1910

9. Birthplaca *(State or Foraign Country)*: Maryland

Usual Residenca of Dacedant

10a. Stata: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Insida City Limits: 1☐ Yas 2☒ No

10a. Street and Numbar: 605 Crosby Road

10f. Zip Coda: 21228

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Navar Married 2☐ Marriad 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No — If Yas, Give Yaar or Dates:

13. Was Decadent of Hispanic Origin? (Spacify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Raca - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highest greda complatad)*: Elamentary/Secondary (0-12): 11 — College (1-4or 5+):

16a. Dacedant's Usuel Occupation *(Give kind of work dona during most of working life. DO NOT usa ratired)*: Grocer

16b. Kind of Business/Industry: Twin Food Stores

17. Fathar's Name *(First, Middla, Last)*: John C. Roe, Sr.

18. Mothar's Nama *(First, Middla, Meidan Surnama)*: Cecil Schlinkmann

19a. Informent's Name/Relationship *(Type, Print)*: Craig Roe (Son)

19b. Mailing Addrass *(Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Code)*: 3711 Ashley Way, Owings Mills, MD 21117

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of cematary, crematory or othar place)*: New Cathedral Cemetery — Data: 12/22/99 — 20c. Location - City or Town, Stata: Baltimore, MD

21. Signature of Funaral Service Licensae: Richard Timm

22. Nama and Addrass of Facility: Witzke Funreal Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the death. Do not antar the mode of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only ona causa on each lina.

Approximata Intervel Batween Onset and Daath

Immadiata Cause (Final diseesa or condition resulting in death): a. Pancreatic cancer — 2 months

Dua to (or as a consequance of):

Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Diseasa or injury that initiated avants resulting in daath) Last:

b. Dua to (or as a consequence of):

c. Dua to (or es e consequanca of):

d.

Part II. **Other significant conditions** contributing to deeth but not rasulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of causa of daath? 1☐ Yas 2☐ No

25. Was case rafarred to medical examinar? 1☐ Yas 2☒ No

26. Piace of Daath *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☒ Othar *(Specify)* Hospice

27. Mannar of Deeth: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be determined

28a. Placa of Injury - At homa, farm, straet, factory, office building, etc. *(Specify)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28e. Deta of Injury *(Month, Day Year)*

28f. Location *(Street and Numbar or Rural Routa Numbar, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, daeth occurred at tha tima, data and placa, and dua to the causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or investigetion, in my opinion, daath occurrad at tha tima, dete end placa, and dua to tha causa(s) end mannar statad.

29b. Signatura and title of cartifiar: [signature] MD

29c. Licensa numbar: D25205

29d. Data signad *(Month, Day, Yaar)*: December 20, 1999

30. Name and addrass of person who completad cause of daath (Item 23a) (Type, Print): W.A. Riley GBMC 6701 N. Charles St. Balto Md 21204

State Registrar

31. Data filed *(Month, Day, Yaar)*: DEC 21 1999

32. Registrer's Signatura: G Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

John Roe 12/20/99 at 6:50 AM

10

AH

99-7567-005
CJ
Elizabeth Riley

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39952

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELIZEBETH R. RILEY
2. Date of Death (Month, Day, Year): December 15 1999
3. Time of Death: 03:43 PM.
4a. Facility Name (If not institution, give street and number): Northwest Hospital Center
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 496-26-2170
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR.18,1926
9. Birthplace (State or Foreign Country): ARKANSAS

Usual Residence of Decedent

10a. State: Md
10b. County: BALTIMORE N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1210 N. SPRING STREET
10f. Zip Code: 21213
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: AFRO-AMERICAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DOMESTIC
16b. Kind of Business/Industry: PRIVATE HOMES

17. Father's Name (First, Middle, Last): REV. C.H.WHITTINGTON D.D.
18. Mother's Name (First, Middle, Maiden Sumeme): RUTH WALKER

19a. Informent's Name/Reletionship (Type, Print): STANLEY E. RILEY / SON
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 5313 ELSRODE AVE BALTO, MD. 21214

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): GARRISON FOREST VET.CEM.
Date: DEC.22,1999
20c. Location - City or Town, Stete: BALTO.CO,MD.

21. Signature of Funeral Service Licensee: Bernadine V. Scruggs
22. Name end Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO,MD. 21213

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on eech line. Approximete Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. Pulmonary Thrombo Embolism Completing Right Knee Injury
Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or es e consequence of):
c. Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☒ Yes 2☐ No
24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year): 12/10/99
28b. Time of Injury: 15 pm M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Subject passenger of vehicle motorcycle accident
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify): roadway
28f. Location (Street and Number or Rural Route Number, City or Town, Stete): 3100 block Monroe Road & Harford Road in Baltimore

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated. 2☒ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) and manner stated.
29b. Signature and title of certifier: Theodore M. King M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): December 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS 4a & 4b PER MD G778 12/21/99 AH

Certificate of Death

Reg. No. 99 39953

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Roland Robinson

2. Dete of Daeth: Month DEC Days 18, Year 1999

3. Time of Deeth: 2:55 AM

4e. Facility Neme (If not institution, give street end number): 2111 WEST FAIRMOUNT AVE

4b. City, Town, or Location of Deeth: BALTIMORE

4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 216-18-0158

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. lest birthday): 74 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Year): Jul 6, 1925

9. Birthplece (State or Foreign Country): MD

Usual Residence of Decedent

10a. Stete: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Insida City Limits: 1 [X] Yes 2 [ ] No

10e. Street end Number: 2111 W. Fairmount Avenue

10f. Zip Code: 21223-

10g. Citizen of Whet Country?: United States

11. Maritel Status: 1 [ ] Naver Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yas, Giva Yaer or Dates: 43-46

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, atc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Bieck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 College (1-4or 5+):

16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired): Laborer

16b. Kind of Business/Industry: Manufacturing

17. Fether's Neme (First, Middle, Last): William Robinson

18. Mother's Name (First, Middle, Maiden Surnema): Agnes Coleman

19e. Informent's Name/Reletionship (Type, Print): Mrs. Myrtle Robinson - Wife

19b. Meiling Address (Street end Number or Rural Route Number, Cify or Town, Stete, Zip Code): 2111 W. Fairmount Avenue, Baltimore, MD 21223

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Garrison Forest V.A.

Dete: Dec 23 1999

20c. Location - City or Town, Steta: Owings Mills, MD

21. Signeture of Funeral Servica Licensee: Glenn L. Williams

22. Name end Address of Fecility: Smith & Williams Funeral Home, P.A. 2818 East Baltimore Street Baltimore, MD

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Pert I. Enter the disaase, or compilcetions that causad the death. Do not enter tha mode of dying, such es cardiac or respiratory arrest, shock, or haart failura. List only one causa on aach line.

Approximeta Intarvel Batwean Onset end Deeth

Immadiata Cause (Final disease or condition resulting in daath)

a. Probable acute myocardial infarction

Due to (or as a consequence of):

b. Arteriosclerotic Heart Disease

Sequentially list conditions, if eny, leading to immediate causa. Enter Undarlying Ceusa (Disaase or Injury thet initieted evants resulting in deeth) Lest

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cauee of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings eveileble prior to completion of cause of daath? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [X] Yes 2 [ ] No

26. Piece of Deeth (Check only ona): Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Rasidanca 6 [ ] Other (Specify)

27. Mannar of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Straet end Number or Rural Routa Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledga, daath occurred et the tima, date end placa, end due to the ceusa(s) and mannar as stated. 2 [ ] **Medical Examinar:** On tha basis of exemination end/or investigation, in my opinion, daath occurred et the time, deta end placa, and dua to tha ceusa(s) end manner steted.

29b. Signature and title of certifier:

29c. License number: D0016263

29d. Date signed (Month, Day, Year): Dec. 20, 1999

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): JUAN A. BELTRAN 1940 W. Baltimore St, Balt., Md 21223

State Registrar

31. Dete filed (Month, Day, Year): DEC 21 1999

32. Registrer's Signeture: Brenda G Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, MDATE

5x1

AH

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene — Reg. No. 99 39954

Amend Item #26, 12/21/99, G778, Per GapPhy, **Certificate of Death**

Pt known as: Louise Smith

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Louise	T.	Smith	December 11, 1999	0512

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sinai Hospital of Baltimore	Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
223-09-0446	1☐ M 2☒ F	87 Yrs.			09 06 12	V.A.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2803 Oswego Ave	21215	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify: NA	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th grade	na	Cook	Edgewood Nursing Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
David Townsend	Florence

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ruby Rease-Niece	3817 Elkader Road, Baltimore Md 21218

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	MD Nat'l Mem. Park	12/16/99	Laurel, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ John March	March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Ruptured Thoracic Aortic Aneurysm	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hypertension	Years
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

GI Bleed

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D0050693	DECEMBER 11, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Aileen G. Peoples, MD 2401 W. Belvedere Ave, Baltimore, MD 21215

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 21 1999	▶ Geneva D Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

RKD

99-7565-510

JOSEPH SAMULES

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39955

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph R. Samuels

2. Date of Death (Month, Day, Year): DECEMBER 15, 1999

3. Time of Death: 5:20P.M.

4a. Facility Name (If not institution, give street and number): 1701 BLOOMINGDALE ROAD

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-40-6162

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 11, 1944

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1701 Bloomingdale Rd.

10f. Zip Code: 21216

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Self-employed

17. Father's Name (First, Middle, Last): Rev. Joseph Samuels

18. Mother's Name (First, Middle, Maiden Sumeme): Edna Petty

19a. Informant's Name/Relationship (Type, Print): Mrs. Fannie Stewart (sister)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3608 Springdale Ave. Balto. Md. 21216

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removel from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piece): Garrison Forest | Date: 12/23/99

20c. Location - City or Town, Stete: Owings Mills, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. | Approximete Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Gastro intestinal hemorrhage

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as e consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic alcoholism

Tuberculosis

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [X] Yes 2 [ ] No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 [X] **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: Stephen S. Radentz, MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): DECEMBER 16, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: Penelope G. Sparks

DHMH 16 Rev 6/95

3+1

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39956

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bonnie O. Sweat
2. Date of Death (Month, Day, Year): DECEMBER 17, 1999
3. Time of Death: 10:25 PM
4a. Facility Name (If not institution, give street and number): 7959 TELEGRAPH ROAD #55
4b. City, Town, or Location of Death: SEVERN
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 412-30-3004
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 19, 1922
9. Birthplace (State or Foreign Country): TENNESSEE

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: SEVERN
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7959 TELEGRAPH RD. #55
10f. Zip Code: 21144
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: AMERICAN INDIAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SEAMSTRESS
16b. Kind of Business/Industry: CLOTHING

17. Father's Name (First, Middle, Last): GEORGE WASHINGTON CADLE
18. Mother's Name (First, Middle, Maiden Surname): POLLY SWEET

19a. Informant's Name/Relationship (Type, Print): SANDY BURCHETTE / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7959 TELEGRAPH RD. #55 SEVERN, MD 21144

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY | Date: DEC. 22, 1999
20c. Location - City or Town, State: CATONSVILLE, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: KIRKLEY-RUDDICK FUNERAL HOMEP.A. 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Myocardial Infarction	< 1 hour
Due to (or as a consequence of): b.	Chronic Obstructive Pulmonary Disease	> 2 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Hypertension	
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John F. Loome, M.D.
29c. License number: D52728
29d. Data signed (Month, Day, Year): 12/20/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John F. Loome, M.D. 479 Jumpo Hole Rd #304 Severna Park, MD 21146

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RKD

99-7612-510
amend item pt.I,PtII 23a, 23a
JAY per me G780 2/18/00 yg
SLATER

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39957

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jay B. Slater

2. Data of Death (Month, Day, Year): DECEMBER 18, 1999

3. Time of Death: 8:04P.M.

4a. Facility Name (If not Institution, give street and number): 5106 ARBUTUS AVE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 249-72-9051

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 54 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): 01 13 45

9. Birthplace (State or Foreign Country): S.C.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 5106 Arbutus Ave

10f. Zip Code: 21215

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade | College (1-4or 5+): 6yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Welder

16b. Kind of Business/Industry: Curtis Bay Coast Guard

17. Father's Name (First, Middle, Last): Murry Slater

18. Mother's Name (First, Middle, Maiden Surname): Annie Mae Ross

19a. Informant's Name/Relationship (Type, Print): Jaylene Slater-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2111 Garrison Blvd, Apt K3, Baltimore Md 21216

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Vet Date: 12/22/99

20c. Location - City or Town, State: Owings Mills, Md

21. Signature of Funeral Service Licensee: Glen March

22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. DIABBETIC KETOACIDOSIS

Due to (or as a consequence of): a. Atherosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): b.

Due to (or as a consequence of): c.

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? Inspection 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephen S. Radentz, MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): DECEMBER 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: Pamela G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

M-541

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39958

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): LILLIAN DARLENE STEVENS
2. Dete of Deeth: Month DECEMBER Day 15 Yeer 1999
3. Time of Deeth: 7:23 pm
4e. Fecility Neme (If not institution, give street end number): HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Deeth: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 318-30-9457
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthday): 66 Yrs.
If Under 1 Yeer: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): Mar 15, 1933
9. Birthplece (State or Foreign Country): Missouri

Usuel Residence of Decedent

10e. Stete: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 3614 Sixth Street
10f. Zip Code: 21225
10g. Citizen of Whet Country?: USA

11. Merital Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - Americen Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 3; College (1-4or 5+): 0
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Fether's Name (First, Middle, Last): Arthur Luten
18. Mother's Neme (First, Middle, Meiden Surneme): Irene Pierce

19a. Informent's Name/Reletionship (Type, Print): Sharon Hall (Daughter)
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 3614 Sixth St., Baltimore, Md. 21225

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Crestlawn Memorial Gdns.
Dete: 12/18/99
20c. Location - City or Town, Stete: Marriottsville, Md.

21. Signeture of Funeral Service Licensee: Kevin E. Ecker
22. Neme end Address of Fecility: McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Balto., Md. 21225-1856

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicetions thet ceused the death. Do not enter the mode of dying, such es cerdiec or respiretory arrest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediete Cause (Finel diseese or condition resulting in death)
e. CHRONIC LYMPHOCYTIC LEUKEMIA — 3 YEARS

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveileble prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one)
Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete end plece, and due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of exemineticn end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: RESIDENT PHYSICIAN
29c. License number: P11949
29d. Date signed (Month, Day, Year): DECEMBER 15 1999

30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print): ABHAY MOGHEKAR, HARBOR HOSPITAL, 3001 S. HANOVER ST., BALTIMORE, MD-21225

State Registrar

31. Dete filed (Month, Day, Year): DEC 21 1999
32. Registrer's Signeture: Geneva G Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

99-7549-510
DDG
UNK 99-317
Travis Stokes

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39959

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TRAVIS LEE STOKES
2. Date of Death (Month, Day, Year): DECEMBER 14, 1999
3. Time of Death: 1205 PM
4a. Facility Name (If not Institution, give street and number): REAR OF 1737 CAREY STREET
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-96-0329
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 19 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 2, 1980
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 3344 Virginia Ave
10f. Zip Code: 21215
10g. Citizen of What Country? USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER
16b. Kind of Business/Industry: Private Industry

17. Father's Name (First, Middle, Last): THOMAS LEE THOMPSON
18. Mother's Name (First, Middle, Maiden Surname): LAWANNA STOKES

19a. Informant's Name/Reletionship (Type, Print): LAWANNA SHERROD-BYRD
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3344 Virginia Ave Baltimore Md 21215

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Cemetery
Date: 12/20/99
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Jerry Harris
22. Name and Address of Facility: CHATMAN-HARRIS F.H. 5240 Reisterstown Road Baltimore, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediete Cause (Finel disease or condition resulting in death): a. Blunt Force Injuries and Asphyxiation
Due to (or es e consequence of):

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Lest:
b.
Due to (or es e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en eutopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? ☒ Yes 2 ☐ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify): SCENE

27. Menner of Death: 1 ☐ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Dete of Injury (Month, Day Year): Found 12-14-99
28b. Time of Injury: Found 12:05 P M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: subject beaten
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify): shed/building
28f. Location (Street and Number or Rural Route Number, City or Town, Stete): 1737 N. Carey St Baltimore, Md

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) end menner es steted.
2 ☒ Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date and piece, end due to the cause(s) and menner steted.

29b. Signature and title of certifier: Dennis J. Chutenp
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): DECEMBER 15, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J. Chutenp 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39960

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Simms

2. Data of Death — Month: December; Day: 14; Year: 1999

3. Time of Death: 12:55pm

4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 220-36-8680

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 59 Yrs.

If Under 1 Year — Months: ; Days: ; If Under 24 Hrs. — Hours: ; Min.:

8. Data of Birth (Month, Day, Year): AUG. 30, 1940

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2504 W. Patapsco Ave., Apt. 1C

10f. Zip Code: 21230

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 9; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: Trucking

17. Father's Nama (First, Middle, Last): Charles W. Simms, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Margaret Stephens

19a. Informant's Name/Reletionship (Type, Print): Teresa Simms - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 2504 W. Patapsco Ave., Apt. 1C, Baltimore, Md. 21230

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Ramoval from State 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore Washington Crm. Data: 12/22/99

20c. Location - City or Town, Stete: Laurel, Md.

21. Signatura of Funaral Service Licensee: ▶ Mary K. Marshall

22. Nama and Address of Facility: Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heert tailure. List only ona ceuse on aach lina.

Approximata Intarval Between Onset and Death

Immediata Causa (Finei disaase or condition rasulting in death)

a. Ischemic Heart Disease — 10 years

Due to (or as e consequence of):

Sequentielly list conditions, if any, leeding to immadiata cause. Enter Underlying Causa (Diseesa or Injury that initiated avants resulting in daeth) Last

b.

Dua to (or as a consequence of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an autopsy performed? 1 [X] Yas 2 [ ] No

24b. Ware autopsy tindings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was casa referred to medical examiner? 1 [ ] Yas 2 [X] No

26. Place of Death (Check only one) — Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner ot Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date ot Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Piece of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Cartifier (Check only one) 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred et the tima, data and place, and dua to tha cause(s) end mennar as stated. 2 [ ] **Medical Examiner**: On tha basis of axamination and/or Investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and mannar stated.

29b. Signatura and titla of cartifiar: ▶ Samuel Ejadi M.D.

29c. License number: RES-006

29d. Date signed (Month, Day, Year): December 14, 1999

30. Nama and addrass ot person who completed causa of death (Item 23a) (Type, Print): Samuel Ejadi, M.D. Johns Hopkins Bayview Medical Center

State Registrar

31. Data filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signatura: Bernard G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39961

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Pamela Lynne Shelby
2. Date of Death: Month December Day 19 Year 1999
3. Time of Death: 2:36AM
4a. Facility Name (If not institution, give street and number): 14 Clairford Court
4b. City, Town, or Location of Death: Arbutus
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 066-68-9148
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 29 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 14, 1970
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Arbutus
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 14 Clairford Court
10f. Zip Code: 21227
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Facilities Coordinator
16b. Kind of Business/Industry: Health Care

17. Father's Name (First, Middle, Last): Edward Howard Budde
18. Mother's Name (First, Middle, Maiden Surname): Mary Catherine Salisburg

19a. Informant's Name/Relationship (Type, Print): Wayne L. Shelby (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14 Clairford Court Arbutus, MD 21227

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.
Date: 12/22/99
20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Service Licensee: Shawn M McLaughlin
22. Name and Address of Facility: Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Lansdowne, MD 21227

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung Cancer — 1yr

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Wm C Waterfield MD
29c. License number: D24356
29d. Data signed (Month, Day, Year): Dec 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Wm C Waterfield St Agnes Comm Center 900 Caton Ave Baltimore MD 21229

State Registrar

31. Data filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: Geneva D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39962

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Louise H. Sparks

2. Date of Death (Month, Day, Year): December 17, 1999

3. Time of Death: 4:35PM

4a. Facility Name (If not institution, give street and number): Charlestown Care Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-44-4564

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 95 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 18, 1904

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decadant

10a. State: VT

10b. County: Addison

10c. City, Town or Location: Cornwall

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 88 Tulley Rd

10f. Zip Code: 05753

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decadant Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decadant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 2

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William Kavanagh Hadel

18. Mother's Name (First, Middle, Maiden Surname): Lula Reid

19a. Informant's Name/Relationship (Type, Print): Kimberly Sparks Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 88 Tulley Rd., Cornwall, VT 05753

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount Cemetery

Date: 12/22/99

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: John D. Shaw

22. Name and Address of Facility: Eline Funeral Home, 11824 Reisterstown Rd Reisterstown, MD 21136

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

20a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart failure — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

gastro intestinal bleeding

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: MD

29c. License number: D47009

29d. Date signed (Month, Day, Year): December 18, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Phillip Stone, 711 Maiden Choice Lane, Catonsville, MD 21228

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: Peter D Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39963

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donald Leroy Shope, Jr.

2. Date of Death: Month Dec. Day 18, Year 1999

3. Time of Death: 9:05 p.m.

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital

4b. City, Town, or Location of Death: Rossville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-92-6830

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 26 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 27, 1973

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland 10b. County: Baltimore 10c. City, Town or Location: Rosedale 10d. Inside City Limits: 1 ☐ Yes 2 X No

10e. Street and Number: 6711 Havenoak Road, Apt. C3 10f. Zip Code: 21237 10g. Citizen of What Country?: United States

11. Marital Status: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Driver

16b. Kind of Business/Industry: Transportation

17. Father's Name (First, Middle, Last): Donald Leroy Shope, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Patricia Mae Lewis

19a. Informant's Name/Relationship (Type, Print): Donald Shope, Sr. (Father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6711 Havenoak Road, Apt. C3 Rosedale, Md. 21237

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hill Mem. Gdns. Date: 12/22/99

20c. Location - City or Town, State: Middle River, Md.

21. Signature of Funeral Service Licensee: Thad W. Fahy

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC COLON CANCER — 6 mos

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael Auerbach

29c. License number: D33551

29d. Date signed (Month, Day, Year): Dec. 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL AUERBACH, 9000 FRANKLIN SQ. DR., Baltimore 21237

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39961

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William A. Sullender
2. Date of Death Month Day Year: December 13 1999
3. Time of Death: 6:58PM
4a. Facility Name *(If not Institution, give street and number)*: Greater Baltimore Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 458-09-5386
6. Sex: 1☐ M 2☐ F (X)
7. Age *(In yrs. last birthday)*: 89 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 23 1910
9. Birthplace *(State or Foreign Country)*: Texas

Usual Residence of Decedent

10a. State: MD.
10b. County: Baltimore
10c. City, Town or Location: Timonium
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 304 Overlook Dr.
10f. Zip Code: 21093
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married (X) 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☐ No (X) If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): ; College (1-4or 5+): +4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Refinery Manager
16b. Kind of Business/Industry: Amaco Oil

17. Father's Name *(First, Middle, Last)*: Levi Brown Sullender
18. Mother's Name *(First, Middle, Maiden Surname)*: Lillian Sternenberg

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Allene Sullender/ Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 304 Overlook Dr. Timonium, MD. 21093

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)* (X)
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hilltop Service Co. — Date: 12-16-99
20c. Location - City or Town, State: Towson, MD.

21. Signature of Funeral Service Licensee: K.A. Pauls
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cx Hemorrhage	4 days
Due to (or as a consequence of): b.	Congestive Heart Failure, due to ASHD	5 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Advanced Renal Disease	5 years
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: E. Hunter Wilson
29c. License number: D12487
29d. Date signed *(Month, Day, Year)*: 12/20/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): E. HUNTER WILSON, M.D. SUITE 203 6BMC BALTO. MD. 21204

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 21 1999
32. Registrar's Signature: Brenda G Sparks

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39965

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Speerstra Stine
2. Date of Death: Month December Day 17, Year 1999
3. Time of Death: 5:20 PM
4a. Facility Name (If not institution, give street and number): Greater Baltimore, Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 298-28-8363
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 69 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 7, 1930
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Edgewood
10d. Inside City Limits: 1 [ ] Yes [X] No
10e. Street and Number: 1002 Lakefront Drive
10f. Zip Code: 21040
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed [X] 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Appraiser
16b. Kind of Business/Industry: Mortgage

17. Father's Name (First, Middle, Last): Oscar Clemens Stine
18. Mother's Name (First, Middle, Maiden Surname): Ritje Speerstra

19a. Informant's Name/Relationship (Type, Print): Mr. Eric Stine/son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13 Woodstream Drive Norristown, PA 19403

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp.
Date: 08/20/99
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ruck Towson Funeral Home, INc. 1050 York Road Towson, Maryland 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction

Due to (or as a consequence of):
b. Heart Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Heart Block

Due to (or as a consequence of):
d. ASCVD

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
sepsis, acute Colitis, carotid artery disease

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X]
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year):
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred:
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M. Alikhan
29c. License number: D14754
29d. Date signed (Month, Day, Year): 12-20-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. ALIKHAN, O'Dea Med. Assoc. Towson, MD 21204

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: [signature] G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39966

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ronald Steinbacher

2. Date of Death: Month 12 Day 12 Year 99

3. Time of Death: 11:29 AM

4a. Facility Name (If not institution, give street and number): University of Maryland Medical System

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 136-34-3510

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 3, 1941

9. Birthplace (State or Foreign Country): Michigan

Usual Residence of Decedent

10a. State: Va.

10b. County: Prince William

10c. City, Town or Location: Manassas

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 9705 Loudoun Avenue

10f. Zip Code: 20109

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Reservation Sales

16b. Kind of Business/Industry: Delta Airlines

17. Father's Name (First, Middle, Last): Raymond Lawrence Steinbacher

18. Mother's Name (First, Middle, Maiden Surname): Virginia Lorraine Tracy

19a. Informant's Name/Relationship (Type, Print): Ronnie F. Gilliam (friend)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9705 Loudoun Avenue, Manassas, Va. 20109

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory

Date: 12/17/1999

20c. Location - City or Town, State: Alexandria, Va.

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Price Funeral Home, Inc. 9609 Center St. Manassas, Va. 20110

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Multi System Organ Failure	2 weeks
Due to (or as a consequence of): b.	Fungal Sepsis	2 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Mediastinitis	2 weeks
Due to (or as a consequence of): d.	Orthotopic Heart Transplant	2 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Malnutrition, Ascites, Immunosuppression

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] Resident Surgeon

29c. License number: D47930

29d. Date signed (Month, Day, Year): 12/12/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles S. Drummond, III, M.D. 22 S. Greene Street Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39967

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELIZABETH C. SITO
2. Date of Death (Month, Day, Year): DECEMBER 18, 1999
3. Time of Death: 0240
4a. Facility Name (If not institution, give street and number): STELLA MARIS MERCY
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213 30 8280
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 68 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APRIL 12, 1931
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: ROSEDALE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8005 CARADOC DRIVE
10f. Zip Code: 21237
10g. Citizen of What Country?: USA
11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ACCOUNTING DEPT
16b. Kind of Business/Industry: GM AUTO
17. Father's Name (First, Middle, Last): JOHN SITO
18. Mother's Name (First, Middle, Maiden Surname): ANNA DRAG
19a. Informant's Name/Relationship (Type, Print): THERESA SADOFSKY / SISTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8015 SAGRAMORE RD BALTIMORE, MD 21237
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ST. STANISLAUS
Date: 12/21
20c. Location - City or Town, State: BALTIMORE, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE BALTIMORE, MD 21237

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Hepatic Failure — 3 weeks
Due to (or as a consequence of):
b. Metastatic Breast Carcinoma — 5 years
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Stella Maris
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D07930
29d. Date signed (Month, Day, Year): December 20, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARVIN JACK FELDMAN 301 St Paul Place Ste 407 Tower Bldg

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: [signature] G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

RKD

99-7613-510

LYDIA

SCHABB

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39968

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
LYDIA		SCHABB	DECEMBER 18, 1999	7:51P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SINAI HOSPITAL	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	If Under 1 Year: Days	If Under 24 Hrs.: Hours	If Under 24 Hrs.: Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-11-4110	1☐ M 2☒ F	15 Yrs.					NOV.23,1984	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3308 SHELBURNE ROAD	21208	u.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		STUDENT	EDUCATION

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
RICHARD	SCHABB	EILEEN	VORBACH

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
RICHARD SCHABB / FATHER	6202 WALLIS AVENUE - BALTIMORE, MD 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	BALTIMORE HEBREW CEMETERY	12/20/99	REISTERSTOWN, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Robert Levinson	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hanging

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Depression

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Inspection 1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Netural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined	12-18-99	Found 1830 M	1☐ Yes 2☒ No	subject hanged self

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Residence	3308 Shelburne Ave Baltimore City, Maryland

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Stephen S. Radentz, MD	O.C.M.E.	DECEMBER 19, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar Signature
DEC 21 1999	Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pagas 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

18

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39969

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MORTON SWEREN
2. Date of Death Month: 12 Day: 17 Year: 99
3. Time of Death: 06:30
4a. Facility Name *(If not institution, give street and number)*: LEVINDALE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-03-9076
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 81 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JUNE 7,1918
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedant

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6316 GREENSPRING AVENUE #201
10f. Zip Code: 21209
10g. Citizen of Whet Country?: U.S.A.

11. Marital Stetus: 1 [ ] Never Merried 2 [X] Merried 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yas, Giva Yeer or Detes: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yas 2 [X] No *Specify:*
14. Race - American Indien, Black, White, atc.: *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SALESMAN
16b. Kind of Business/Industry: AUTOMOBILE

17. Father's Neme *(First, Middle, Last)*: SAMUEL SWEREN
18. Mother's Name *(First, Middle, Maiden Surneme)*: REBECCA LEVITSKY

19a. Informent's Neme/Ralationship *(Type, Print)*: SHIRLEY SWEREN / WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 6316 GREENSPRING AVENUE #201 - BALTIMORE, MD 21209

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: KNESSETH ISRAEL CEMETERY
Date: 12/19/99
20c. Location - City or Town, Stete: ANNAPOLIS, MD

21. Signature of Funeral Service Licensee: Scott M. Cuttle
22. Name end Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter tha disaase, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or haart failure. List only one cause on aech lina.

Approximete Intarvel Between Onset end Deeth

Immediate Ceuse (Final diseese or condition resulting in deeth):
e. SEPSIS — 2 DAYS.

Due to (or es a consequance of):
b. LIVER DISEASE — 5 YEARS

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initieted evants resulting in death) Last

Due to (or es e consequence of):
c. MAJOR DEPRESSION — 10 YEARS.

Due to (or es e consequence of):
d. ATRIAL FIBRILLATION — 10 YEARS.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Deeth *(Check only one)*: Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Homa 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Mannar of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending invastigation 6 [ ] Could not be determined

28a. Data of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, ferm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to tha causa(s) and menner as stated. 2 [ ] **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, daath occurred at tha time, data end piece, and due to the ceuse(s) end mannar steted.

29b. Signeture end title of certifier: Donna M. Eversley M.D
29c. License number: D0054739
29d. Dete signed *(Month, Dey, Year)*: 12-17-99

30. Neme end eddress of person who completed causa of death (Item 23a) (Type, Print): DONNA EVERSLEY, 24340 W. BELVEDERE, BALTIMORE, MARYLAND 21215

State Registrar

31. Deta filed *(Month, Dey, Year)*: DEC 21 1999
32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39970

TRUMAN, Hilda
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HILDA E TRUMAN
2. Date of Death Month Day Year: December 18, 1999
3. Time of Death: 4:05 AM
4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-30-1438
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 24 1913
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7 Glenwood Road
10f. Zip Code: 21221
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Yaar or Datas:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, Whita, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elemantary/Secondary (0-12): 8th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk
16b. Kind of Business/Industry: Silbers Bakery

17. Father's Nama *(First, Middle, Last)*: Otto Lehmann
18. Mother's Name *(First, Middle, Maiden Surname)*: Pauline Schuster

19a. Informant's Name/Reletionship *(Type, Print)*: Carolyn Glass / daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P,O,Box 1093 Pasadena Maryland 21123-1093

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holly Hill Cemetery — Data: 12/21/99
20c. Location - City or Town, Stata: Baltimore MD.

21. Signature of Funarel Sarvice Licensee: R. Terry Connelly
22. Nama and Address of Facility: Connelly Funeral Home of Essex, 300 MAce Ave. Baltimore Md. 21221

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failure. List only ona causa on eech line. — Approximate Intervet Between Onset and Death

Immediate Ceuse (Finel disaesa or condition rasulting in death)
a. Ischemic Bowel — 12 hours
Dua to (or as a consequence of):
b.
Dua to (or as a consequence of):
Sequantially list conditions, if any, leeding to immadieta causa. Entar Underlying Cause (Disaase or Injury that initiated evants rasulting in daath) Last
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa given in Part I.: Coronary Artery Disease, Congestive Heart Failure, Pulmonary Fibrosis, Dementia, osteoarthritis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa referred to medical examinar? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other *(Specify)*

27. Mannar of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding invastigation 6☐ Could not be datermined
28a. Data of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifiar: Allen Forsythe MD
29c. License number: RD196618
29d. Data signed *(Month, Day, Year)*: 12/18/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Allen Forsythe, MD 9000 Franklin Square Drive Baltimore MD 21237

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 21 1999
32. Registrar's Signatura: Jennie G Sparks

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours aftar death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39971

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Minnie Trust

2. Date of Death: Month 12 Day 15 Year 99

3. Time of Death: 3 30 p.m.

4a. Facility Name (If not institution, giva street and number): GOOD SAMARITAN NURSING CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-05-4493

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 94 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 12 1905

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1523 Marshall Street

10f. Zip Code: 21230

10g. Citizen of What Country? USA

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+): 0

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Home Owner

17. Father's Nema (First, Middle, Last): Martin Holmstead

18. Mother's Name (First, Middle, Maiden Surname): Mary Orlandinski

19a. Informent's Name/Reletionship (Type, Print): J. Donald Morfe (Nephew)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code): 3513 Woodring Ave. Baltimore, Md. 21234

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Moreland Memorial Park Dete: 12/17/99

20c. Location - City or Town, Stete: Baltimore, Md.

21. Signeture of Funeral Service Licensee: George M. Hampton Jr.

22. Name end Address of Facility: McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart lailura. List only one cause on aach tina.

Approximete Intervel Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death) a. CONGESTIVE HEART FAILURE — 2 mos

Dua to (or es a consequence of): b. HYPERTENSION — 30 yrs

Sequentially tist conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Due to (or as e consequence of): c.

Due to (or es e consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: CHRONIC OBSTRUCTIVE LUNG DIS.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yas 2☒ No

24b. Wara eutopsy findings available prior to completion of cause of death? 1☐ Yas 2☒ No

25. Was casa referred to medical examiner? 1☐ Yas 2☒ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at tha tima, data end place, end dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, daath occurred at tha tima, data and piece, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier: Charles F. Hoesch MD

29c. License number: D20390

29d. Date signed (Month, Day, Year): 12/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES F. HOESCH MD; 9712 BELAIRE RD; BALTIMORE 21236

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit pass.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39972

Physician /Medical Examiner

1. Decedent's Nsme *(First, Middle, Last)*: FRANK COSEN TURNER
2. Date of Death Month Dey Year: 12-16-1999
3. Time of Death: 08:25AM
4a Fscility Name *(If not institution, give street and number)*: ER FALLSTON GENERAL HOSPITAL
4b. City, Town, or Location of Death: FALLSTON
4c. County of Death: HARFORD

Funeral Director

5. Sociel Security Number: 215-28-7332
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 68 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Dste of Birth *(Month, Day, Year)*: 5-15-1931
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. Stste: MD
10b. County: Harford
10c. City, Town or Location: Joppa
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street snd Number: 452 Macintosh Circle
10f. Zip Code: 21085
10g. Citizen of What Country?: USA
11. Marital Status: 1☐Never Married 2☒Msrried 3☐Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Wss Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Rsce - American Indian, Bleck, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 6th — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver
16b. Kind of Business/Industry: Monumental Supply
17. Father's Name *(First, Middle, Last)*: Cosen Turner
18. Mother's Name *(First, Middle, Maiden Surname)*: Gertrude Cusiting
19s. Informant's Name/Relationship *(Type, Print)*: Arlene Turner spouse
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 452 Macintosh Circle, Joppa, Maryland 21085
20e. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removel from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Oaklawn Cemetery
Dste: 12/18/99
20c. Location - City or Town, Stste: Baltimore, Maryland
21. Signature of Funeral Service Licensee: Maria G. Zannino
22. Nsme and Address of Fecility: Joseph N. Zannino Jr., Funeral Home, 263 S. Conkling Street, Baltimore, Maryland 21224

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicstions thst caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line. — Approximste Interval Between Onset and Death

Immediate Ceuse (Finel disesse or condition resulting in deeth): s. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or ss s consequence of):

Sequentielly list conditions, if sny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lsst

b. Due to (or es s consequence of):

c. Due to (or es e consequence of):

d.

Pert fl. **Other signifIcsnt conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Wes an autopsy performed? 1☐Yes 2☒No

24b. Were sutopsy findings evsilable prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Deeth: 1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and plece, end due to the cause(s) and manner ss steted. 2☒ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end plece, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: DME
29c. License number: 0CME
29d. Date signed *(Month, Day, Year)*: DEC 16 1999

30. Nsme and sddress of person who completed cause of death (Item 23a) (Type, Print): GPWABHJ M.D. 218 Fulford NE BELAIR MD 21014

State Registrar

31. Date filed *(Month, Dey, Year)*: DEC 21 1999
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Turner, Frank 12/16/99 0825

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39973

Certificate of Death

Reg. No.

John Toth

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Charles Toth
2. Date of Death (Month, Day, Year): December 20, 1999
3. Time of Death: 3:00pm
4e. Facility Name (If not institution, give street and number): 1534 east Clement Street
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-26-7102
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 20, 1928
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10e. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 1534 E. Clement Street
10f. Zip Code: 21230
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: Navy 1951-55
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist
16b. Kind of Business/Industry: Manufacturing

17. Father's Name (First, Middle, Last): Louis Toth
18. Mother's Name (First, Middle, Maiden Surname): Katherine Tasner

19e. Informent's Name/Relationship (Type, Print): Leonard J. Toth / Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5701 Chatham Road, Brooklyn Park Maryland 21225

20e. Method of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Cross Cemetery, December
Date: 23, 1999
20c. Location - City or Town, State: Baltimore Maryland

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.
22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

Physician /Medical Examiner

23e. Pert1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert feilure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in deeth)
a. Myocardial Infarction — 1 Hours
Due to (or es e consequence of):
b. Coronary Artery Disease — 10-15 YRS
Due to (or es a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest
c.
Due to (or es a consequence of):
d.

Pert tt. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical exeminer? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D0005093
29d. Date signed (Month, Day, Year): December 20, 1999

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Colen C. Heinritz, MD 3001 South Hanover Street, Baltimore Maryland 21225

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39974

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Data of Death (Month, Day, Year)	3. Time of Death
ROSE	TEXER	DECEMBER 19, 1999	2:25 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ARDEN COURT ASSISTED LIVING	PIKESVILLE	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-18-0039	1☐ M 2☒ F	89 Yrs.			APR.20,1910	WASH., D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒ Yes 2☐ No

10a. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3328 CLARKS LANE #F	21215	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		MANICURIST	COSMETOLOGY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JOSEPH GNESSIN	ETHEL SHAPIRO

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
DIANE WEINGROFF / DAUGHTER	3916 SYBIL ROAD - RANDALLSTOWN, MD 21133

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	ZION LIBERTY PARK OF SHAAREI	12/20/99	RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. myocardial infarction	minutes
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. anemia	months
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) ASSISTED LIVING

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D37573	December 20,1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jeff Zibell MD 7220 Park Heights Ave Baltimore MD 21208

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 21 1999	▶ Geneva D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39975

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: PHILIP VAN GELDER

2. Dete of Deeth Month / Dey / Year: DECEMBER 17, 1999

3. Time of Death: 19:50

4e. Feciility Neme *(If not institution, give street end number)*: ST. AGNES HOSPITAL

4b. City, Town, or Location of Deeth: BALTIMORE

4c. County of Deeth:

Funeral Director

5. Social Security Number: 184-07-8916

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. lest birthday)*: 92 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: 8/22/1907

9. Birthplece *(Stete or Foreign Country)*: NEW YORK

Usual Residence of Decedent

10e. Stete: MD

10b. County: BALTIMORE

10c. City, Town or Location: CATONSVILLE

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street end Number: 221 GRALAN ROAD

10f. Zip Code: 21228

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Yeer or Detes: WWI

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: UNION ORGANIZER

16b. Kind of Business/Industry: I A M

17. Fether's Neme *(First, Middle, Lest)*: HENRY VAN GELDER

18. Mother's Neme *(First, Middle, Malden Sumame)*: HELEN (FOOTE)

19e. Informant's Neme/Relationship *(Type, Print)*: MIRIAM VAN GELDER (WIFE)

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 221 GRALAN ROAD CATONSVILLE, MD 21228

20e. Method of Disposition: 1 ☐ Burial 2 ☒ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*: BALTO. WASH. CREMATORY

Dete: 12/19/99

20c. Location - City or Town, State: LAUREL, MD

21. Signeture of Funeral Service Licensee: Susan R. C...

22. Neme end Address of Feciility: WITZKE FUNERAL HOMES, INC. 1630 EDMONDSON AVENUE CATONSVILLE, MD 21228

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complications that cause the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel disease or condition resulting in deeth)

e. myocardial infarction — one hour

Due to (or es e consequenca of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in deeth) Lest

b. Coronary artery disease — twenty years

Due to (or es e consequenca of):

c.

Due to (or as e consequenca of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Colon cancer, Alzheimer Dementia

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical exeminer? 1 ☐ Yes 2 ☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1 ☐ Inpetient 2 ☒ ER/Outpetient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Deeth: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner es steted. 2 ☐ **Medical Exeminer:** On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier:

29c. License number: BG5446996

29d. Dete signed *(Month, Dey, Year)*: December 17, 1999

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Robert Greenwalk M.D. 900 Caton Avenue, Baltimore md. 21229

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 21 1999

32. Registrar's Signeture: Donna G Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Philip VanGelder

BY

AH

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39976

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DONALD, WILSON

2. Date of Death Month Day Year: DECEMBER 17, 1999

3. Time of Death: 2345 PM

4a. Facility Name *(If not institution, give street and number)*: NORTHWEST HOSPITAL 5401 OLD COURT RD

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 213-28-6451

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MAY 24, 1930

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Randallstown

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 9109 Liberty Road

10f. Zip Code: 21133

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1947-1951

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 5 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Electrician

16b. Kind of Business/Industry: Industrial

17. Father's Name *(First, Middle, Last)*: Edwin Wilson

18. Mother's Name *(First, Middle, Maiden Surname)*: Naoma Young

19a. Informant's Name/Relationship *(Type, Print)*: Margaret E. Mills/sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1714 Mar Sue Drive Hampstead, MD 21074

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory, Inc. Date: 12/20/99

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn F. McDonald

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. LIVER FAILURE — FOUR DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. SEPSIS — FOUR DAYS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*: Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mamatha S. Ananth HOSPITALIST

29c. License number: 0053439

29d. Date signed *(Month, Day, Year)*: DECEMBER 17, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MAMATHA S. ANANTH NORTHWEST HOSPITAL, 5401 OLD COURT ROAD, RANDALLSTOWN MD 21133

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 21 1999

32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item #26, 12/21/99, G778, per GaDi phy

Certificate of Death

Reg. No. 99 39977

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Victoria	Catherine	Williams	12	14	1999	8:00am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3942 Setonhurst Road	Pikesville	Baltimore Co.

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-20-4885	1☐ M 2☒ F	78 Yrs.			02 14 21	S.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1913 Cedric Road	21216	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th grade	na	Counselor	Rosewood Hospital

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles Nelson	Mary Johnson

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
McClinton Williams-Son	3942 Setonhurst Road, Pikesville Md 21208

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Data	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Garrison Forest Vet	12/21/99	Owings Mills, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Gladys Warner	March West 4300 Wabash Ave, Balt, MD 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only one cause on aach line.

		Approximata Intarval Between Onset and Death
Immediate Causa (Final disease or condition resulting in death)	a. Cardiac Arrthymia	
	Dua to (or as a consequenca of):	
Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ASCVD	
	Due to (or as a consequence of):	
	c.	
	Dua to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

Diabetes

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was casa referrad to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☒ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Data signed (Month, Day, Year)
▶ Ismail E. Bunch, M.D.	D16941	12/15/99

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

21 Crossroad Dr, Ste 400, Owings Mills, MD 21117

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signature
DEC 21 1999	▶ D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39978

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Delores Laverna Wojcik
2. Date of Death (Month, Day, Year): December 14, 1999
3. Time of Death: 10:00AM
4a. Facility Name (If not institution, give street and number): 8870 Cherrylane
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 219.26.9144
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 8, 1939
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8870 Cherrylane
10f. Zip Code: 20708
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Louis Bortner
18. Mother's Name (First, Middle, Maiden Surname): Anna Pierman

19a. Informant's Name/Relationship (Type, Print): Louise Salandanan/Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 2 Box 178 I Greenwood, DE 19950

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Mem. Park
Date: 12/20
20c. Location - City or Town, State: ElkRidge, Md

21. Signature of Funeral Service Licensee: Anthony Peters
22. Name and Address of Facility: Gary L. Kaufman Funeral Home at Meadowridge 7250 Washington Blvd., Elkridge, Md. 21075

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. RESPIRATORY FAILURE
Due to (or as a consequence of):
b. CHRONIC LUNG DISEASE
Due to (or as a consequence of):
c. ASTHMA
Due to (or as e consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2☐ Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, dale and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Neil A. Meade MD
29c. License number: D19220
29d. Date signed (Month, Day, Year): 12-20-99

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Neil A. Meade 9811 Millard Drive Laurel MD 20708

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

mdcate

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 39979

Certificate of Death

Reg. No.

WHITEHEAD, VIOLA

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Viola A. Whitehead

2. Date of Death (Month, Dey, Year): DECEMBER 19 1999

3. Time of Death: 7:45PM

4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 212-18-7180

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 17, 1909

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Jessup

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1863 Montevideo Rd.

10f. Zip Code: 21085

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Byers

18. Mother's Name (First, Middle, Maiden Sumeme): Rosine Schmidt

19a. Informant's Name/Relationship (Type, Print): Robert Whitehead - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 716 Joppa Farm Rd., Joppa, Md. 21085

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Meadowridge Mem. Park | Date: 12/22/99

20c. Location - City or Town, State: Elkridge, Md.

21. Signature of Funeral Service Licensee: ▶ Mary K. Marshall

22. Name and Address of Facility: Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEPTICEMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings sveilable prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ M.D.

29c. License number: D51664

29d. Date signed (Month, Day, Year): DECEMBER 19 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUDHIR KUMAR AGGARWAL NORTH ARUNDEL HOSPITAL, 301 HOSPITAL DRIVE, GLEN BURNIE, MD 21061

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: ▶ General G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

WRC amend item 23a, PtII per me 2/18/00 yg
99-7576-027
ARTHUR W.
WALLING

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39980

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Arthur W. Walling
2. Date of Death (Month, Day, Year): DECEMBER 16, 1999
3. Time of Death: 11:15 AM.
4a. Facility Name *(If not institution, give street and number)*: 7401 ASSATEATEAGUE RD.
4b. City, Town, or Location of Death: JESSUP
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 250.72.3666
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 54 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 03.18.1945
9. Birthplace *(State or Foreign Country)*: South Carolina

Usual Residence of Decedent

10a. State: SC
10b. County: Orangeburg
10c. City, Town or Location: Orangeburg
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2475 Riley St.
10f. Zip Code: 29118
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver
16b. Kind of Business/Industry: Trucking

17. Father's Name *(First, Middle, Last)*: Vernie Walling
18. Mother's Name *(First, Middle, Maiden Surname)*: Ola (Hoover)

19a. Informant's Name/Relationship *(Type, Print)*: Sandra Walling/ Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2475 Riley St. Orangeburg, SC 29118

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Caughman-Harman Crematory — Date: 12/21/99
20c. Location - City or Town, State: Lexington, SC

21. Signature of Funeral Service Licensee: ▶ Mark Marshall
22. Name and Address of Facility: Gary L. Kaufman Funeral Home @Meadowridge Mem.Park Cem Inc.7250 Washington Blvd.Elkridge,MD21075

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. DIABETIC KETOACIDOSIS

Due to (or as a consequence of): b. ~~Hypertensive and Atherosclerotic Cardiovascular Disease~~

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.: HYPERTENSIVE AND ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)*: AT SCENE

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ J Pestaner M.D
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: DECEMBER 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 21 1999
32. Registrar's Signature: ▶ B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39981

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen White
2. Date of Death: Month 12 Day 17 Year 1999
3. Time of Death: 10:30 p.m.
4a. Facility Name (If not institution, give street and number): 9448 Tiller Dr.
4b. City, Town, or Location of Death: Ellicott City
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 008-26-1991
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3/24/34
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9448 Tiller Dr.
10f. Zip Code: 21042
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): John MacLeod
18. Mother's Neme (First, Middle, Maiden Surname): Elizabeth B. Beard

19a. Informant's Name/Relationship (Type, Print): David White - Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9448 Tiller Dr. Ellicott City, MD 21042

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Placa of Disposition (Name of cemetery, cremetory or other place): Baltimore National Cem.
Date: 12/21/99
20c. Location - City or Town, State: Catonsville, MD

21. Signeture of Funeral Service Licensee: Bernard Dalnoski
22. Name and Address of Facility: Sterling-Ashton-Schwab Funeral Home, Inc. 736 Edmondson Ave. Catonsville, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. — Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. metastatic adenocarcinoma — 2 mos.
Due to (or aa a consequence of):
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated eventa resulting in deeth) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D40850
29d. Date signed (Month, Day, Year): December 20, 1999
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): YVONNE OTTAVIANO MD 900 CATON AVE BALTIMORE MD 21229

State Registrar

31. Dete filed (Month, Day, Year): DEC 21 1999
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39982

Patient Known as: JOHN WIGGINS

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Wesley Wiggins, Jr.

2. Date of Death (Month, Day, Year): DECEMBER 18, 1999

3. Time of Death: 14:56

4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL OF BALTIMORE

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 212-01-1132

6. Sex: XX 1 M 2 F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 19, 1919

9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: Md.

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: XX 1 Yes 2 No

10a. Street and Number: 4905 Poe Avenue

10f. Zip Code: 21215

10g. Citizen of What Country? USA

11. Marital Status: XX 1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forcas? XX 1 Yes 2 No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 XX No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11th Grade

College (1-4or 5+):

16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Assistant Supervisor

16b. Kind of Business/Industry: Coca Cola

17. Father's Name (First, Middle, Last): John W. Wiggins , Sr.

18. Mother's Name (First, Middle, Maiden Surname): Susan F. Fonville

19e. Informant's Name/Relationship (Type, Print): Nancy Middleton sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3905 Mondawmin Avenue Baltimore, Md. 21216

20a. Method of Disposition: XX 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Othar (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Garrison Forrest Veterans

Date: Dec. 27

20c. Location - City or Town, Stete: Owings Mills, Md.

21. Signatura of Funaral Service Licensee: Herbert E. Nutter

22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in deeth)

a. HYPOXIC / ANOXIC BRAIN INJURY — 12 hours

Due to (or as a consequence of):

b. SEPTIC SHOCK — 12 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated evants resulting in death) Last

Due to (or as e consequence of):

c. RIGHT ABOVE-KNEE AMPUTATION — 3 days

Dua lo (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PERIPHERAL VASCULAR DISEASE

END-STAGE RENAL DISEASE

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was en eutopsy performed? 1 Yes 2 XX No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1 Yas 2 No

25. Was case referred to medical examiner? 1 Yes 2 XX No

26. Place of Death (Check only one)

Hospitel: 1 XX Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 8 Othar (Specify)

27. Manner of Death: 1 XX Neturel 2 Accident 3 Suicide 4 Homicide 5 Panding investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 XX **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and plece, end due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: SURGICAL HOUSE OFFICER

29c. License number: RES-000

29d. Date signed (Month, Day, Year): DECEMBER 18, 1999

30. Nama and address of person who completed cause of death (Item 23e) (Type, Print): DR. SRINIVAS K. PRASAD, MD. SINAI HOSPITAL OF BALTIMORE

State Registrar

31. Data filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39983

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bonnie Porter Wingate
2. Date of Death: Month December Day 19 Year 1999
3. Time of Death: 5:30 am
4a. Facility Name (If not institution, give street and number): 76 Owensville Road
4b. City, Town, or Location of Death: West River
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 217-26-9002
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 12,1923
9. Birthplace (State or Foreign Country): Australia

Usual Residence of Decedent

10a. Stete: MD
10b. County: Anne Arundel
10c. City, Town or Location: West River
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 76 Owensville Road
10f. Zip Code: 20778
10g. Citizen of What Country?: Australia

11. Meritel Stetus: 1☐ Naver Merried 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 2
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): Arthur Porter
18. Mother's Neme (First, Middle, Maiden Sumame): May White

19a. Informant's Neme/Reletionship (Type, Print): Judith D. Wingate (Daughter)
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 76 Owensville Road, West River, MD 20778

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): Christ Church Cemetery
Dete: 12/22
20c. Location - City or Town, Stete: West River, MD

21. Signeture of Funeral Service Licensee: Michael P. Hutta
22. Name end Address of Feciility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediete Causa (Final diseese or condition resulting in death)
a. Cacherid of malignancy — 6 wks
Due to (or as e consequence of):
b. metastatic lung carcinoma — 4 months
Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in deeth) Lest
Due to (or es a consequence of):
c. lung carcinoma LLL — 4 months
Due to (or es a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.
non-insulin dependent Diabetes Mellitus
Coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one)
Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigetion 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date and piece, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner steted.

29b. Signeture and title of certifier: Gyl C Samaras MD
29c. License number: D08317
29d. Date signed (Month, Day, Year): 12/30/99

30. Name end address of person who completed causa of death (Item 23a) (Type, Print): GEORGE C SAMARAS MD 205 Ridgely Ave Annapolis MD 21401

State Registrar

31. Date filed (Month, Day, Year): DEC 31 1999
32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39984

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Eleanor Barbara Watson

2. Date of Death — Month: December; Day: 19; Year: 1999

3. Time of Death: 6:20 AM

4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 074-14-1078

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Yaer — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Data of Birth *(Month, Day, Year)*: May 28, 1920

9. Birthplaca *(State or Foreign Country)*: New York

Usual Rasidanca of Decedent

10a. Stata: MD

10b. County: Anne Arundel

10c. City, Town or Location: Odenton

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 1242 Duke Lane

10f. Zip Code: 21113

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Raca - Amarican Indian, Black, White, atc. *Specify:* White

15. Decedant's Education *(Specify only highast grada complatad)*: Elamantary/Secondary (0-12): ; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working lifa. DO NOT use retired)*: Secretary

16b. Kind of Businass/Industry: US Government

17. Fathar's Nama *(First, Middla, Last)*: Charles McClellan

18. Mother's Nama *(First, Middle, Maiden Surnama)*: Theresa Unknown

19a. Informant's Name/Relationship *(Type, Print)*: Dorothy Strootman (Daughter)

19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 561 West Drive, Severna Park, MD 21146

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Nama of cematary, crematory or other place)*: Maryland Veterans Cem.

Data: 12/21

20c. Location - City or Town, Stata: Crownsville, MD

21. Signeture of Funeral Service Licensee: Michelle P. Lutte

22. Nama and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Entar tha diseasa, or complications that caused tha daath. Do not entar tha moda of dying, such as cardiac or raspiratory errest, shock, or heart failura. List only ona causa on aach lina.

Approximata Interval Between Onset and Death

Immediata Causa (Final disaasa or condition resulting in death)

a. Chronic Obstructive Pulmonary Disease — Years

Due to (or as a consequence of):

Sequantially list conditions, if any, laading to immedieta causa. Enter Underlying Causa (Disease or Injury that initiated avents resulting in daath) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was casa referred to medical examinar? 1☐ Yas 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Rasidence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Date of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to tha cause(s) and mannar stated.

29b. Signatura and title of certifiar: George E. Wicks III M.D.

29c. License number: D41365

29d. Data signed *(Month, Day, Year)*: December 19, 1999

30. Nama and addrass of person who complatad cause of death (Item 23a) (Type, Print): George E. Wicks III M.D. 301 Hospital Drive, Glen Burnie, MD 21061

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 21 1999

32. Registrer's Signatura: Jeanne G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Watson, Eleanor

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Amended Item#5 perFH G778 12/29/99 EW

Reg. No. 99 39985

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
MOLLIE	WELKY	DECEMBER 19 1999	2:39 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-30-~~3157~~ 3154	1☐ M 2☒ F	82 Yrs.			Apr. 19, 1917	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6911 Conley Street	21224	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9 years		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Lawrence Dietz	Barbara Zak

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Barbara J. Falkenstein (Daughter)	6930 Gough Street Baltimore, Maryland 21224

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Holy Redeemer Cemetery	12/22/99	Baltimore, Maryland

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE MYOCARDIAL INFARCTION	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Gail Berkenblit MD	RES000	DECEMBER 20 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Gail Berkenblit 4940 Eastern Ave. Baltimore, Md. 21224

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 21 1999	▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39986

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARGARET F. WOLF

2. Date of Death — Month: DEC. Day: 17 Year: 1999

3. Time of Death: 10:45AM

4a. Facility Name *(If not institution, give street and number)*: 1226 Kirby Circle

4b. City, Town, or Location of Death: Belair

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 218-74-3141

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 15, 1912

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore County

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4900 White Marsh Rd.

10f. Zip Code: 21237

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 12 — College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Housekeeping-Own Home

17. Father's Name *(First, Middle, Last)*: James Burns

18. Mother's Name *(First, Middle, Maiden Surname)*: Barbara Dougherty

19a. Informant's Name/Relationship *(Type, Print)*: Miss Charlotte F. Wolf (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1226 Kirby Circle Belair, Maryland 21015

20a. Method of Disposition: ☒1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parkwood Cemetery — Date: 12-19-1999

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Lassahn Funeral Home 7401 Belair Rd. Baltimore, Maryland 21236

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Alzheimers Disease

Due to (or as a consequence of):

b. Congestive Heart Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: History of Pneumonia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* DAUGHTER'S HOUSE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Hi Sup Sim

29c. License number: D4642

29d. Date signed *(Month, Day, Year)*: 12/17/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Hi Sup Sim 39 S. Union Ave Havre De Grace MD 21078

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 21 1999

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified as soon.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39987

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ethel Florence Young

2. Data of Death Month Day Year: Dec. 16, 1999

3. Time of Death: 11:40 A.M.

4a Facility Name (If not institution, give street and number): Mariner Health of Glen Burnie

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 214-12-2487

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 26, 1912

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1612 Wall Dr.

10f. Zip Code: 21122

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9th Grade

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Packer

16b. Kind of Business/Industry: Factory

17. Father's Name (First, Middle, Last): William Carson Bosley

18. Mother's Name (First, Middle, Maiden Surname): Daisey Mae Unknown

19a. Informant's Name/Relationship (Type, Print): Nancy L. Rush Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 147 Englar Wood Dr. Sebastian Fl. 32958

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Mem. Park

Data: 12/20/99

20c. Location - City or Town, State: Glen Burnie MD

21. Signature of Funeral Service Licensee: Christina L. Hilton

22. Name and Address of Facility: McCully-Polyniak Funeral Home, PA. 3204 Mountain Rd. Pasadena Md. 21122

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Pulmonary Disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M. Delaney MD

29c. License number: D-40521

29d. Date signed (Month, Day, Year): December 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D.R. OCHANEY 3350 Wilkens Avenue Suite 302 Baltimore, MD 21229

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

13

State Registrar

31. Date filed (Month, Day, Year): DEC 21 1999

32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39988

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Genevieve Anthon

2. Date of Death: Month December Day 18, Year 1999

3. Time of Death: 5:25 P.M.

4a. Facility Name (If not institution, give street and number): Cherrywood Nursing Home

4b. City, Town, or Location of Death: Reisterstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-12-8811

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 16, 1920

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Pikesville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 602 Carysbrook Road

10f. Zip Code: 21208

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+): -0-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Insurance

17. Father's Name (First, Middle, Last): Edward Leo Starr

18. Mother's Name (First, Middle, Maiden Surname): Genevieve C. Hogan

19a. Informant's Name/Relationship (Type, Print): James R. Anthon - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 602 Carysbrook Road; Pikesville, Maryland 21208

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery

Date: 12/22/99

20c. Location - City or Town, State: Woodlawn - Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Cerebral Vascular Accident — 2 months

Due to (or es a consequence of): Atherosclerotic Vascular Disease — 20 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as e consequenca of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end piece, end due to the ceuse(s) and manner steted.

29b. Signature and title of certifier: [signature] Copeland MD

29c. License number: D27034

29d. Date signed (Month, Day, Year): December 22 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ira Hunter Copeland MD 5310 Old Court Road Randallstown MD 21133

State Registrar

31. Date filed (Month, Day, Year): DEC 22 1999

32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'naturel', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#22 perFH G778 12/22/99 EW

Certificate of Death

Reg. No. 99 39989

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Wilma Louise Alford

2. Date of Death Month / Day / Year: December 19 1999

3. Time of Death: 04:10

4a. Facility Name *(If not institution, give street and number)*: Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 247-56-5929

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 63 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 6-24-1936

9. Birthplace *(State or Foreign Country)*: S.C.

Usual Residence of Decedent

10a. State: Md

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2256 Cecil Avenue

10f. Zip Code: 21218

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6th grade — College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Les Goodson

18. Mother's Name *(First, Middle, Maiden Surname)*: Willie Bacote

19a. Informant's Name/Relationship *(Type, Print)*: Dozier Alford - Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2256 Cecil Avenue Baltimore, Md 21218

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Crownsville Veteran — Date: 12-23-99

20c. Location - City or Town, State: Crownsville, Md

21. Signature of Funeral Service Licensee: Debra M. [illegible]

22. Name and Address of Facility: Hardy F.H. ~~West~~ East 1101 E North Avenue Balto, Md 21202

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediete Cause (Final disease or condition resulting in death)
a. Massive Hemorrhage From A-V Fistula of ~~The~~ Left arm — 30 mins

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequenca of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

End Stage Renal Disease
Stroke

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature], M.D.

29c. License number: AT2438946

29d. Date signed *(Month, Day, Year)*: 12/19/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PEIQING GAO, The Union Memorial Hospital

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 22 1999

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39990

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANNIE AVERY

2. Date of Death: Month DEC Day 17 Year 1999

3. Time of Death: 1.00PM

4a. Facility Name (If not institution, give street and number): BONSECOURS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-32-1449

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 64 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): 04-23-35

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 1228 N. AUGUSTA AVENUE

10f. Zip Code: 21229

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10 TH GRADE

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DIETARY AIDE

16b. Kind of Business/Industry: HEALTH CARE

17. Father's Name (First, Middle, Last): HENRY DUNMORE

18. Mother's Name (First, Middle, Maiden Surname): REBEECA BUFFORD

19a. Informant's Name/Relationship (Type, Print): CYNTHIA AVERY / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 462A PARKTON ST., BALTO. MD. 21229

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): BALTO. NATL. CEMETERY

Date: 12-27-99

20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: Vaughn C Greene

22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL. PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC RENAL FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. DIABETES MELLITUS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PERIPERAL VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Vasanthakumar

29c. License number: D42510

29d. Data signed (Month, Day, Year): 12/17/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. VASANTHAKUMAR MD 821 N. EUTAW ST # 407 MD 21201

State Registrar

31. Data filed (Month, Day, Year): DEC 22 1999

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39991

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas M. Balducci
2. Date of Death: Month December Day 17, Year 1999
3. Time of Death: 3:40 P.M.
4a. Facility Name (If not institution, give street and number): Stella Maris
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-01-1289
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02/14/1917
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4520 Mainfield Avenue
10f. Zip Code: 21214
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Coil Cleaner
16b. Kind of Business/Industry: Self-Employed
17. Father's Name (First, Middle, Last): Thomas Balducci
18. Mother's Name (First, Middle, Maiden Surname): Catherine Faber
19a. Informant's Name/Relationship (Type, Print): Mr. Thomas M. Balducci, Jr./Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20314 West Liberty Road, White Hall, MD 21161
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery
Data: 12/21/99
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: Christina L. David
22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, Maryland 21214

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on aech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lymphoma
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as e consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.: Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings available prior to completion of causa of death? 1 [ ] Yas 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residance 6 [X] Other (Specify) Hospice

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D43725
29d. Data signed (Month, Day, Year): 12/20/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TARIQ MAHMOOD 201-109 Back River Neck Road Baltimore MD 21221

State Registrar

31. Data filed (Month, Day, Year): DEC 22 1999
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39992

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROBERT JOSEPH BAVIS

2. Date of Death Month Day Year: DECEMBER 20, 1999

3. Time of Death: 08:55AM

4a Facility Name *(If not institution, give street and number)*: Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 705-14-0966

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 22, 1919

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Glen Arm

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 11630 Glen Arm Road

10f. Zip Code: 21057

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Salesman

16b. Kind of Business/Industry: Meat Packing Co.

17. Father's Name *(First, Middle, Last)*: Robert Joseph Bavis, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Edna Lammert

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Mary P. Bavis (wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11630 Glen Arm Road, Glen Arm, MD 21057

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dulaney Valley Mem'l Gar

Date: 12/23/99

20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused tha death. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Batwaan Onsat and Death

Immediate Ceuse (Final disease or condition resulting in death)

a. PNEUMONIA — 3 DAYS

Due to (or as a consequence of):

b. CHRONIC OBSTRUCTIVE LUNG DISEASE — YEARS

Sequentially tist conditions, if eny, laading to immediata cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

Dua to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

END STAGE SENILE DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Wara autopsy findings available prior to completion of cause of daath? 1 [ ] Yes 2 [X] No

25. Was case referred to medicat examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To tha best of my knowledge, death occurred at the tima, data and place, and due to tha cause(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, date and placa, and dua to tha cause(s) and manner steted.

29b. Signetura end title of certifier: Beatriz P. Dizon, M.D.

29c. License number: D16492

29d. Data signed *(Month, Dey, Year)*: December 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BEATRIZ P. DIZON, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State Registrar

31. Date filed *(Month, Dey, Year)*: DEC 22 1999

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39993

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elena J. Bondar

2. Date of Death: Month December Day 20 Year 1999

3. Time of Death: 0255

4a. Facility Name (If not institution, give street and number): Fallston General Hospital

4b. City, Town, or Location of Death: Fallston

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 213-82-4166

6. Sex: 1☐ M 2☒ F

7. Age (in yrs. last birthday): 87 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): May 24, 1912

9. Birthplace (State or Foreign Country): Russia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Sparks

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3 Glencoe Manor Court

10f. Zip Code: 21152

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th Grade | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Ivan Nosov

18. Mother's Name (First, Middle, Maiden Surname): Akulina Brukhanova

19a. Informant's Name/Relationship (Type, Print): Mrs. Linda Korenczuk (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 Glencoe Manor Ct., Sparks, MD 21152

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery

Date: 12/22/99

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Brian D. Lewis

22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each lina.

Approximata Interval Between Onset and Death

Immediate Causa (Final disease or condition resulting in death)

a. Pulmonary Edema

Due to (or as a consequence of):

b. Ischemic Heart Disease — yrs

Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and mannar stated.

29b. Signature and title of certifier: Joseph Reinhardt

29c. License number: D15673

29d. Date signed (Month, Day, Year): Dec. 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Joseph Reinhardt, 2003 Rock Spring Rd., Forest Hill, MD 21050

State Registrar

31. Date filed (Month, Day, Year): DEC 22 1999

32. Registrar's Signature: Brenda G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Bondar, Elena

1/5/10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39994

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James A. Barnes

2. Date of Death: Month December Day 19 Year 1999

3. Time of Death: 1400

4a. Facility Name (If not institution, give street and number): Fallston General Hospital

4b. City, Town, or Location of Death: Fallston

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 214-01-0035

6. Sex: 1 ☑ M 2 ☐ F

7. Age (In yrs. last birthday): 84 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 09/09/1915

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: BelAir

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 208 Victory Lane

10f. Zip Code: 21014

10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Factory Worker

16b. Kind of Business/Industry: Smelting and Refining

17. Father's Name (First, Middle, Last): John Peter Barnes

18. Mother's Name (First, Middle, Maiden Surname): Nancy J. Dalton

19a. Informant's Name/Relationship (Type, Print): James E. Barnes / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 208 Victory Lane BelAir, Maryland 21014

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Crematory

Date: 12/21/99

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Mark T. Zaragoza

22. Name and Address of Facility: Schimunek Funeral Home of BelAir, Inc. 610 W. MacPhail Road BelAir, Md. 21014

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. SEPSIS

Due to (or as a consequence of):

b. DIABETES MELLITUS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. PERIPHRAL VASCULAR DISEASE

Due to (or as a consequence of):

d. RENAL FAILURE

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: MD

29c. License number: D45921

29d. Date signed (Month, Day, Year): DECEMBER 20, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SYED F. MAHMOOD 4-C NORTH NORTH AVENUE SUITE 424 BEL AIR MARLAND 21014

State Registrar

31. Date filed (Month, Day, Year): DEC 22 1999

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Barnes, James

12

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39995

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George M. Boston
2. Date of Death: Month December, Day 17, Year 1999
3. Time of Death: 2:05PM
4a. Facility Name (If not institution, give street and number): Baltimore VA Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 213-05-4378
6. Sex: [X] M [ ] F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): June 17, 1911
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: [X] 1 Yes [ ] 2 No
10e. Street and Number: 4100 Ethland Avenue
10f. Zip Code: 21207
10g. Citizen of What Country?: USA

11. Marital Status: [ ] 1 Never Married [ ] 2 Married [X] 3 Widowed [ ] 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? [X] 1 Yes [ ] 2 No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) [ ] 1 Yes [X] 2 No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8th Grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction Worker
16b. Kind of Business/Industry: unknown

17. Father's Name (First, Middle, Last): George Washington Boston
18. Mother's Name (First, Middle, Maiden Surname): Viola Squirrell

19a. Informant's Name/Relationship (Type, Print): daughter Carolyn Byrd-Ryan
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4100 Ethland Avenue Baltimore, Md. 21207

20a. Method of Disposition: [X] 1 Burial [ ] 2 Cremation [ ] 3 Removal from State [ ] 4 Donation [ ] 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forrest Veterans Data: Dec. 27
20c. Location - City or Town, State: Owings Mills, Md.

21. Signature of Funeral Service Licensee: Ernest R. Curry Jr.
22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Lung Cancer
Due to (or as a consequence of):
b. Pneumonia
Due to (or as a consequence of):
c. Sepsis
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? [X] 1 Yes [ ] 2 No [ ] 3 Probably [ ] 4 Unknown

24a. Was an autopsy performed? [ ] 1 Yes [X] 2 No
24b. Were autopsy findings available prior to completion of cause of death? [ ] 1 Yes [ ] 2 No

25. Was case referred to medical examiner? [ ] 1 Yes [X] 2 No
26. Place of Death (Check only one): Hospital: [X] 1 Inpatient [ ] 2 ER/Outpatient [ ] 3 DOA; Other: [ ] 4 Nursing Home [ ] 5 Residence [ ] 6 Other (Specify)

27. Manner of Death: [X] 1 Natural [ ] 2 Accident [ ] 3 Suicide [ ] 4 Homicide [ ] 5 Pending Investigation [ ] 6 Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? [ ] 1 Yes [ ] 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): [X] 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [ ] 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kimberly L. Bolling M.D.
29c. License number: P12370
29d. Date signed (Month, Day, Year): December 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kimberly L. Bolling Baltimore VA Medical Center 10 North Greene St. Baltimore MD

State Registrar

31. Date filed (Month, Day, Year): DEC 22 1999
32. Registrar's Signature: Denise G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39996

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ellenor Colgate Buzby
2. Date of Death — Month: December; Day: 16; Year: 1999
3. Time of Death: 5:15PM
4a. Facility Name *(If not institution, give street and number)*: College Manor, Inc.
4b. City, Town, or Location of Death: Lutherville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-46-3166
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 28, 1917
9. Birthplace *(State or Foreign Country)*: New York

Usual Residance of Dacedant

10a. Stete: Maryland
10b. County: Baltimore
10c. City, Town or Location: Lutherville
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 300 W. Seminary Ave.
10f. Zip Code: 21093
10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Naver Marriad 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Race - Amarican Indian, Black, Whita, atc. *Specify:* white

15. Decedant's Education *(Specify only highast grada compliated)* — Elamentary/Secondery (0-12): 12; Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: homemaker
16b. Kind of Business/Industry: own home

17. Fathar's Nama *(First, Middla, Last)*: Craig Colgate
18. Mother's Name *(First, Middle, Maiden Sumame)*: Sally Brigham

19a. Informent's Name/Ralationship *(Type, Print)*: Ellenor B. Jarrett/daughter
19b. Meiling Address *(Street end Number or Rural Routa Number, City or Town, Stete, Zip Code)*: 10530 Burnside Farm Rd. Stevenson, MD 21158

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Ramoval from Stata 4☐ Donetion 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nema of cemetery, cremetory or other piece)*: Greenmount Crematory
Data: 12/18/99
20c. Location - City or Town, Stata: Baltimore, Maryland

21. Signature of Funeral Servica Licensee: John O. Mitchell IV
22. Nama and Addrass of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad the deeth. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only one cause on aach line. — Approximata Intervel Between Onset and Deeth

Immedieta Causa (Final disease or condition resulting in deeth)
e. pancreatic cancer — Dua to (or as a consequence of):

Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaase or injury that initiated avents resulting in death) Last
b. — Due to (or as a consequence of):
c. — Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No
24b. Wara autopsy findings available prior to compiation of cause of death? 1☐ Yas 2☐ No

25. Was casa referred to medical examinar? 1☐ Yas 2☑ No
26. Placa of Death *(Check only ona)* — Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Othar *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be determined
28a. Data of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)* 1☑ **Certifying Physician**: To tha best of my knowledga, death occurred at tha tima, data and place, end due to the ceuse(s) end manner es stated. 2☐ **Medical Examiner**: On tha basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and mannar stated.

29b. Signature and title of certifier: Bruce Rosenberg MD
29c. Licensa number: D24124
29d. Data signed *(Month, Day, Year)*: 12/17/99

30. Name and addrass of person who compliated causa of death (Item 23e) (Type, Print): Bruce Rosenberg, M.D. 21 West Rd. Towson, MD 21204

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 22 1999
32. Registrar's Signatura: Geneva G Sparks

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ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39997

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM LEO BENDGEN
2. Date of Death (Month, Day, Year): December 19.1999
3. Time of Death: 8:20AM
4a. Facility Name *(If not institution, give street and number)*: Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 235-20-8141
6. Sex: 1☒M 2☐F XX
7. Age *(In yrs. last birthday)*: 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: December 18,1920
9. Birthplace *(State or Foreign Country)*: West Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No XX
10e. Street and Number: 203 East Melrose Avenue
10f. Zip Code: 21212
10g. Citizen of What Country?: USA
11. Marital Status: 1☐Never Married 2☐Married XX Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? XXX Yes 2☐No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.): 1☐Yes 2☒No XX *Specify:*
14. Race - Americen Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales & Service
16b. Kind of Business/Industry: Fuel Injection
17. Father's Name *(First, Middle, Last)*: Daniel Bendgen
18. Mother's Name *(First, Middle, Maiden Surname)*: Rose Greiner
19a. Informant's Name/Relationship *(Type, Print)*: Mary Anne Rochfort DTR
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6031 Bellona Avenue Baltimore, Maryland 21212
20a. Method of Disposition: XX 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: Parkwood Cemetery
Date: 12/22/99
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: Dennis Stephen Kenaley
22. Name end Address of Facility: Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Adenocarcinoma of esophagus — 3 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part i.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒**Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: W.A. Riley, MD
29c. License number: D25205
29d. Date signed *(Month, Day, Year)*: December 19, 1999

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): W.A. Riley GBMC 6701 N. Charles St. Balto. md 21204

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 22 1999
32. Registrar's Signature: D Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Bendgen, William 12/19/99 8:20AM

AH 12

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39998

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): James Robert Brown, Jr.

2. Dete of Deeth: Month 12 Dey 18 Yeer 99

3. Time of Death: 9:30 am

4a. Facility Name (If not institution, give street end number): Stella Maris Hospice

4b. City, Town, or Location of Death: Timonium

4c. County of Deeth: Baltimore

Funeral Director

5. Social Security Number: 212-01-6968

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 99 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Day, Year): November 20, 1900

9. Birthplace (Stete or Foreign Country): Maryland

Usuel Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 216 Homewood Terrace

10f. Zip Code: 21218

10g. Citizen of Whet Country?: United States

11. Merital Stetus: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12) / College (1-4or 5+): 3

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): attorney

16b. Kind of Business/Industry: legal

17. Father's Neme (First, Middle, Last): James Robert Brown

18. Mother's Neme (First, Middle, Maiden Sumeme): Catherine Crump

19a. Informant's Neme/Reletionship (Type, Print): James R. Brown, III/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 5 Running Fox Rd. Glen Arm, MD 21057

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Greenmount Cemetery

Dete: 12/22/99

20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signeture of Funerel Service Licensee: John D. Mitchell IV

22. Neme end Address of Fecilit: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediete Cause (Final disease or condition resulting in deeth): a. End Stage Dementia

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one) Hospitel: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [✓] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end plece, and due to the ceuse(s) end menner stated.

29b. Signeture and title of certifier: Jaimie

29c. License number: D43725

29d. Date signed (Month, Day, Year): 12/21/99

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): TARIQ MAHMOUD 201-109 Back River Neck Road Baltimore MD 21221

State Registrar

31. Date filed (Month, Day, Year): DEC 22 1999

32. Registrar's Signeture: Jennie D Sparks

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Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 39999

AMEND 20c PER F.H. G778 12-21-99 J.A.

NAME KNOWN TO PHYSICIAN
BARR, ELLIOTT S.
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last): Elliott Barr			2. Date of Death (Month, Day, Year): November 12, 1999		3. Time of Death: 6:39 PM
4a. Facility Name (If not institution, give street and number): VA Maryland Health Care System	4b. City, Town, or Location of Death: Perry Point	4c. County of Death: Cecil			
5. Social Security Number: 053-22-6774	6. Sex: 1 [X] M 2 [ ] F	7. Age (In yrs. last birthday): 69 Yrs.	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year): Jul.9,1930
9. Birthplace (State or Foreign Country): NY					

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince Georges	Bowie	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
12309 Round Lane	20715	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Line Type Operator	Printing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Herman Barr	Rose Goldhair

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
John Barr/ Brother	12309 Round Tree Lane - Bowie, MD 20715

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	MD Veterans Cemetery	11-19-99	CROWNSVILLE, MD. ~~Owings Mills, MD~~

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Robert Grossman Per DVR	Sol Levinson & Bros., Inc. 8900 Reisterstown Road Pikesville, MD21208

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Respiratory Failure due to Pneumonia	Unknown
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Pancreatic Cancer with Liver Metastasis	Unknown
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [X] Yes 2 [ ] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D41608	December 13, 1999

30. Name and address of person who completed cause of death (Item 29b) (Type, Print)
EUGENE CRAIG, M.D., VA Maryland Health Care System. Perry Point, MD 21902

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 22 1999	▶

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 40000

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VINCENT S.COMELLA, SR.

2. Date of Death (Month, Day, Year): December 21, 1999

3. Time of Death: 10:41 am

4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: AA COUNTY

Funeral Director

5. Social Security Number: 217.09.2981

6. Sex: 1☐ M 2☐ F — X

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY23, 1914

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1☐ Yes 2☒ No — X

10e. Street and Number: 715 DELMAR AVE.

10f. Zip Code: 21061

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced — X

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — X — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No — X — Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): MANAGER

16b. Kind of Business/Industry: GROCERY

17. Father's Name (First, Middle, Last): PHILIP COMELLA

18. Mother's Name (First, Middle, Maiden Surname): ELIZABETH CORTESE

19a. Informant's Name/Relationship (Type, Print): VINCENT S. COMELLA, JR./SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 211 LINHIGH AVE. BALTIMORE, MD. 21236

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) — X

20b. Place of Disposition (Name of cematary, crematory or other place): GLEN HAVEN CEMETERY

Date: 12.24.99

20c. Location - City or Town, State: GLEN BURNIE,MD

21. Signature of Funeral Service Licensee: KELLY GREGORY FINK

22. Name and Address of Facility: FINK FUNERAL HOME,PA
426 CRAIN HWY. SW GLEN BURNIE,MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line.

Approximata Interval Between Onset and Death

Immediata Causa (Final disease or condition resulting in death): a. Ventricular Fibrillation — min

Due to (or as a consequence of): b. Coronary Artery Disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c. Atherosclerotic Heart Disease — years

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No — X

26. Placa of Death (Check only one)

Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Homa 5☐ Rasidence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury (Month, Day, Year)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To tha best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D

29c. License number: D02583

29d. Date signed (Month, Day, Year): 12/21/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 301 Hospital Drive Glen Burnie md 21061

State Registrar

31. Date filed (Month, Day, Year): DEC 22 1999

32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Comella Vincent

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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